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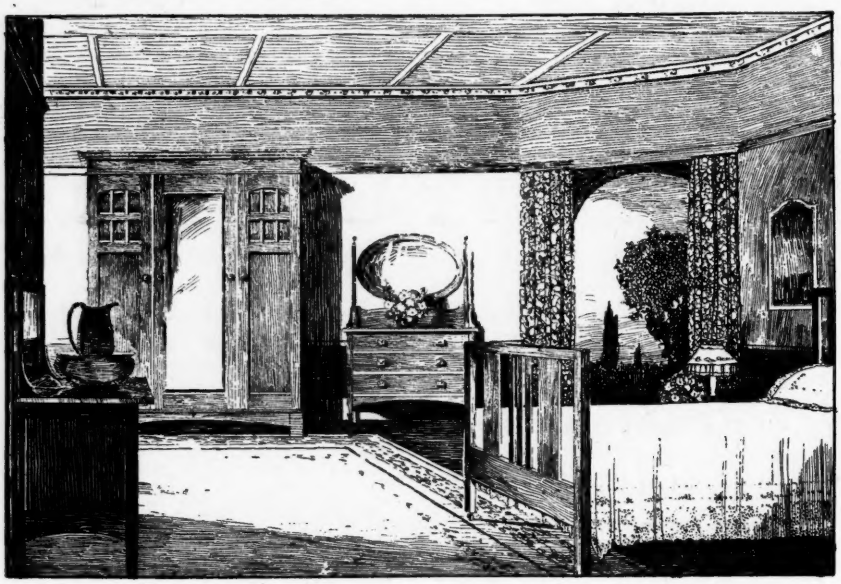

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—7TH YEAR. SYDNEY: SATURDAY, FEBRUARY 7, 1920. No. 6.

ON ACUTE RHEUMATIC HEART DISEASE.

By **J. Macdonald Gill, M.D. (Lond.),**

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In a recent paper on cardiac murmurs I discussed briefly the mode of production of the murmurs of rheumatic heart disease. I now intend to discuss rheumatic heart disease as a whole from the standpoint of that paper, the subject of murmurs naturally making one think of rheumatism and how it leads to disease of the heart.

Rheumatism is emphatically a disease of childhood. It is unknown before the age of four years and begins to be common at five. After fifteen years it occurs commonly enough, of course, but does not seriously damage the heart. The age of incidence is then from five to fifteen years, and, roughly speaking, the younger the child, the severer the heart affection is apt to be. A child affected with rheumatism is almost sure to have it again; and each relapse is apt to affect the heart. The clinical manifestations of rheumatism, apart from the heart trouble, are often vague and indefinite; so vague and indefinite are they that, no doubt, they are often entirely forgotten in after life. They produce no permanent changes and the symptoms are easily removed by the salicylates.

The heart trouble, on the other hand, is permanent and usually progressive and is uninfluenced by salicylates. In fact, the arthritis is of quite minor importance, while the heart trouble is all-important. That being so, we generally base our diagnosis of acute rheumatism on the result of the examination of the heart, coupled with the effect of salicylates on the arthritis.

Ætiology.

The ætiology of rheumatism is still uncertain. Wet and damp are generally supposed to play a large part in leading to it. I think, in childhood, that is a secondary factor. There appears to be little difference in the incidence of the disease in dry climates and in wet, or in the children of the well-to-do and the poor, who presumably are more likely to be exposed to wet and damp. But there is generally a marked family history of the disease and the virtual limitation of the severe form to the early years of life is certainly striking. Chorea is to be looked upon merely as a cerebral manifestation of rheumatism. It is just as likely to lead to heart disease. The bacteriology is still unsettled. Poynton and Paine's researches should be referred to in this connexion. What they have succeeded in reproducing in experimental animals seems to me to be an ulcerative endocarditis. Poynton seems to admit that, but asserts, in answer thereto, that there is no essential difference between simple and septic endocarditis. All one can say is that there is a very great difference clinically; ulcerative endocarditis is almost invariably fatal in a few months or weeks from the result of the infective disease of the valves, while simple endocarditis is a chronic disease, leading in the course of years to chronic heart disease. Their work may be in part true, but in the absence of confirmation one can only suspend one's judgement.

Three Forms.

Rheumatic heart disease occurs essentially in three forms. These forms overlap one another, so that the general term carditis is often used.

The Pericarditic Type.

The first type is that in which pericarditis is the most obvious feature and which generally leads to a fatal result in a few days or weeks. When the extensive nature of the disease is seen in the post-mortem room, with the sodden, grey, flabby myocardium, one does not wonder at death taking place so soon.

Myocardial Type.

The next type is the myocardial, so-called because the brunt of the incidence falls on the myocardium. There may or may not be pericarditis, but of a much milder type than the foregoing. There are usually pericardial adhesions, because any coincident pericarditis, being less severe, is not immediately fatal.

Endocardial Type.

The third type is the endocardial. In this there are usually no pericardial adhesions and the mischief is limited almost entirely to the valves, especially the mitral. This type rarely leads to serious trouble in childhood, but in adolescence or adult life produces the chronic heart disease with which we are all only too familiar. Occasionally the aortic valves are involved, leading in time to puckering and shrinking and hence incompetence. Aortic incompetence is very rare in children, two or three cases only having come under my care. In these there had been previous attacks of rheumatism, the children being admitted to hospital for the ordinary symptoms of heart failure and not for rheumatism. The earliest age at which I have heard a presystolic murmur, is thirteen years. In one case in which I was able to follow the case up from childhood there was an apical systolic murmur till about the age of eighteen years, when a presystolic murmur appeared. I need not say anything more about this type, as it is rather a remote result of rheumatism. Moreover, it is familiar to everyone from its frequent occurrence in the adult. When it does occur in childhood, it produces very similar symptoms. Nor need I discuss the first type, the pericarditic, any further, as its clinical features present no particular difficulty.

But the myocardial type is the most characteristic of childhood; it is the form I wish especially to discuss now. To understand the rheumatic heart properly, it is first necessary to understand how heart failure is brought about. Any view of heart failure must be based on the views held of the normal action of the heart. In other words, physiology comes first, pathology second. The modern view is that in the normal heart, the contraction wave begins at a cer-

tain point, the sinu-auricular node, spreads thence over the auricle and passes from auricle to ventricle by means of the *a—v* bundle, the *a—v* node presiding over the activity of the ventricles. The heart initiates its own contraction wave, which is not dependent on mechanical conditions of proper filling with blood and so on. This differs from the old view that the different chambers contract only when a proper degree of tension is reached.

Based on this, it was thought that, when the heart failed, it was due to gradual or occasionally sudden over-distension of the ventricles. Little attention was paid to the condition of the auricles. Thus we commonly hear and read of acute and chronic dilatation of the heart as a cause of sudden death. Sudden death in rheumatic heart disease is very rare. Death almost always comes after prolonged illness, unless there is pericarditis, when death may follow after a few days or a few weeks. In these cases, the size of the heart does not materially alter before death; in fact, the heart may remain of the same size for weeks or months and finally death comes, with no alteration in the physical signs. It is certain that in these cases the cavities of the heart are nearly always a good deal dilated for many months before death. Death often takes place unexpectedly. No doubt these patients are capable of very little effort. They spend their time in bed, propped up by pillows, hardly able even to speak, month after month, till some small, untoward event, *e.g.*, an attack of bronchitis, carries them off. No doubt the heart is heavily handicapped by the dilatation of its chambers. It might be plausibly argued that the heart failed because of the dilatation, if we did not know what occurred in other diseases. In the heart failure of diphtheria, the heart is, as a rule, not dilated, as I have myself repeatedly observed in the post-mortem room, in spite of the most extensive myocardial degeneration. Any theory of heart failure, to be satisfactory, must be of general application. We know, too, that in elderly people, death from sudden heart failure may occur and the heart show no dilatation whatever. In fact, it may show very little to account for the sudden death. Evidently, in these cases, the heart, for reasons which differ in different cases, is unable to initiate its contraction. No doubt, in the rheumatic heart, the final stoppage is essentially of similar nature. We are compelled to inquire whether there is any morbid change in the heart itself, sufficient to account for death. I may at once say that there is none. The heart is always hypertrophied, sometimes enormously, may even weigh 450 grammes or more. There are usually, but not always, pericardial adhesions. The muscle, to the naked eye, looks good, is of good colour and of normal appearance. There are no fibroid patches and the pericardial adhesions do not appear to involve the ventricular musculature. On microscopic examination, the ventricular musculature may show islands of slight fatty degeneration which are so common that one cannot attach much importance to them. The valvular changes are obviously inadequate to explain the heart failure. The mitral valve alone is usually affected. The valve generally shows vegetations at or near the margin and there may be some thickening, but it is often very little deformed and may even be not obviously affected and may be quite clearly competent. It is usual in such cases to put the trouble down to the pericardial adhesions, which are generally, but not always, present. I am strongly of the opinion that the pericardial adhesions have very little to do with the failure of the heart and for these reasons: Firstly, although pericardial adhesions are usually present, yet sometimes they are altogether absent, although the heart muscle shows the usual hypertrophy and other changes exactly similar. Secondly, pericardial adhesions are often accidentally found in the post-mortem room, in cases where the heart has never given any trouble during life. While it is generally admitted that pericardial adhesions of themselves need not cause any embarrassment of the heart, as they are so often found unexpectedly in the post-mortem room, yet many authors hold the opinion that if the adhesions are firm and close, or tie the heart closely to the thoracic wall, the heart becomes embarrassed, gradually hypertrophies and ultimately fails. But that is not the rule in the rheumatic heart, as I have frequently observed. The adhesions are usually limited to the inner surface of the pericardium, the outer surface being almost always free; moreover, the adhesions are usually soft and not dense or close, in fact, not essentially different from those found in non-rheumatic cases. One must suppose that the hypertrophy of the heart is quite independent of the adhesions. Further, the hypertrophy involves the auricles, as well as the two ventricles. In the post-mortem notes of one of my cases, it is noted that the muscular structure of the right auricle was much hypertrophied, all parts seemed to share in the hypertrophy, the pectinate fibres being two or three times as thick as normal. The muscle looked good to the naked eye.

It is clear from all this that the hypertrophy is the essential factor in rheumatic heart infection. Valvular disease is obviously not able to explain it, more especially as the valves may be quite normal. Pericardial adhesions cannot explain it. We are forced to assume that the hypertrophy is due to some other cause. The mere study of morbid anatomy can carry us no further. It is well now to consider the clinical side. Of course, the hypertrophy is obvious clinically; the forcible, heaving impulse, extending far beyond its normal position, the extensive area of dulness, the protrusion of the chest wall in front of the heart are all familiar features. This shows very clearly how forcibly the heart beats. The contrast between this powerful beat and the feeble pulse in the arteries is very striking. Again, the rhythm of the pulse is usually quite normal. Complete arrhythmia is very rare in rheumatic heart failure in childhood. Only once have I seen it during the last ten years or so. In that case, in a girl, aged 10 years, the pulse became completely irregular, about a fortnight before death. I took a radial tracing, but could not get a venous pulse record, owing to the laboured breathing. These patients generally fail gradually and very rarely indeed manifest any irregularity of the pulse. I can speak positively as to this, as at one time I thought that a study of pulse irregularities might help. I found, however, that it did not. But an obvious and familiar feature is, of

course, the production of murmurs. I need not describe these in any detail, as they are so familiar. All I need say is, that, as a rule, the greater the hypertrophy the louder the murmur. In my previous paper I discussed the mode of production of these murmurs and said that I thought that they were muscular vibrations, arising in the right auricle and hence transmitted to the ventricles and, further, that the only structure which could give rise to them was the *sinus venosus* tissue incorporated in the right auricle. In the rheumatic heart, I believe, murmurs are so evident, because this sinus tissue is more active and more vigorous and that it is directly connected with the hypertrophied heart. In the rheumatic heart the hypertrophy is the essential factor; not being due to a mechanical cause, it must be vital. The usual complete absence of irregularities show that there is no interruption of the path of the cardiac impulse; hence it is highly improbable that any gross myocardial disease occurs, which, of course, is borne out by the study of morbid anatomy. The problem is very obscure and one can only guess as to how this hypertrophy is produced. My own idea is that the rheumatic poison, probably a toxin, because it acts continuously, for weeks or months, acts on the heart muscle and hypertrophy follows. If one accepts the modern physiological notion that the heart initiates its own contraction and that that contraction always begins at a certain point and follows a definite course in the normal heart, then the heart will hypertrophy if this impulse is constantly more powerful, just as a skeletal muscle will hypertrophy if constantly forced to contract more forcibly than normal. If this view be true, the converse must also be true; if for any reason, *e.g.*, failure of nutrition, old age, etc., this impulse (stimulus-production Gaskell calls it) fails, then the heart fails.

It would be idle to speculate as to the part played by the internal secretions. We constantly see this in the case of the thyroid gland. In exophthalmic goître we see how an internal secretion can stimulate the heart to excessive activity. Remove the abnormal secretion and the heart returns to the normal immediately. This example demonstrates how the heart reacts to an excessive stimulus from outside. I do not mean to suggest that in rheumatism an outside factor is at work. Of that there is no evidence. I think that the cardiac muscle is damaged in some way we do not quite understand and that the heart overcomes it, in the only way it can, that is, by hypertrophy; that that hypertrophy involves the whole heart, right as well as left ventricle and auricle as well.

In conclusion, I should like to emphasize the importance of the study of rheumatic heart disease in children. Rheumatism produces its most characteristic effects in childhood. The rheumatic heart disease of the adult differs widely from that of the child.

TUBERCULIN.

By **J. F. Spring, M.D. (Melb.),**
Oculist, St. Vincent's Hospital, Melbourne.

The use and abuse of tuberculin have long been interwoven, till at the present day probably half the practitioners in this country class it as useless; some consider it harmful and many of those who use it, are so doubtful about their results that they do not administer it regularly or persistently.

Those interested in treatment by tuberculin, whether in the past or present, will have agreed or disagreed with various writers as to (*i.*) the size of the dose, (*ii.*) the intervals at which doses should be administered, (*iii.*) the type of tuberculin to be used. They will in relation to (*ii.*) have thought considerably about questions of negative and positive phases and will agree that in choosing the interval, they would wish to give the second dose at the height of a positive phase. They will perhaps also have considered whether or not it is possible to avoid a negative phase altogether. In this article I do not propose to deal with the subject other than clinically, but will strive to draw some deductions from clinical findings.

Working from an ophthalmic point of view it is possible in many cases definitely to see the results obtained and thus to tell much more accurately when minute changes are taking place than is possible in most tubercular conditions of the general system. I have been trying to satisfy myself on three points: (1) Has tuberculin any curative effect in cases of scrofula? (2) If useful, in what doses should it be used? (3) At what intervals should injections be given?

Results so far have been interesting, but not necessarily conclusive. The number of cases dealt with is small and this article is written in the hope of persuading other oculists to investigate the subject on similar lines, as one man's material and time is, of course, limited.

Some years ago I had the fortune to see at St. Vincent's Hospital, a few patients who resisted all local and general drug treatment. The cases varied a little, but were mostly of the type known generally as marginal blepharitis. One girl (M.J.) had a severe and persistent phlyctenular conjunctivitis, which had been for some time under treatment elsewhere. I may as well state at once that this case has been one of the most interesting, but the only disappointing one in my series. It was, however, her case which first suggested this investigation and I will refer to her again later. Having put this girl on tuberculin with some passing success, I sought fresh fields and picked on some cases of chronic marginal blepharitis. At that time I was not familiar with Fuchs's statements on this subject. Before going further I will quote from his work two short paragraphs which are interesting.

> Blepharitis is distinguished by its eminently chronic course, which often extends over years. In young patients the disease often disappears of itself when they grown up, in others it continues during the whole life. Proper treatment always produces considerable improvement or even effects a cure, which later, however, is in most cases not lasting, as after the discontinuance of the treatment the disease usually returns; a permanent cure is obtained in only a few cases.
>
> The general causes lie partly in the constitution of the patient, partly in external injurious influences. In the first category are to be mentioned anæmia, scrofula and tuberculosis, which, particularly in children and young people, furnish a frequent cause of blepharitis. When with increasing age the constitution improves, the blepharitis disappears.

After quoting these remarks from Fuchs, which illustrate the chronic nature of this disease and the possibility of a tubercular basis, I proceed to my cases without further elaboration.

The first patient (E.V.) was aged 24 years. The von Pirquet test gave a positive reaction. She came under observation about two and a half years ago and was suffering from chronic marginal blepharitis of the squamous type. Various local remedies were tried during a period of fourteen months with no success. At this stage tuberculin was commenced. She was started with a dose of 0.00005 mgr. T.R. once in 14 days in addition to local treatment. Two weeks later the dose was increased to 0.0001 mgr. and after a similar interval 0.00013 mgr. was given. After this last dose the eyes flared up with definitely increased injection of the lids and conjunctiva. She was then treated with 0.00005 mgr. fortnightly for about two months with little or no success. The tuberculin was then stopped and local treatment alone tried again. As, however, this failed to give any improvement after a period of six months, tuberculin was resumed in smaller doses, 0.00002 mgr. every 14 days, and on these doses she did consistently well, until there was no trace of any squamous condition left, the only remnant of her trouble being some enlargement of the small vessels at the lid margins. Since her apparent cure, she has been put on weekly injections, first 0.00001 mgr., but gradually raised to 0.0001. mgr without any reaction or recurrence. At this stage she has found it necessary to leave Melbourne for Sydney and has for the present passed beyond my observation.

In this case it seemed (1) that tuberculin cured, at any rate temporarily, a lesion which proved quite intractible to other treatment. (2) Doses of 0.00005 mgr. did little or no good. (3) A larger dose of 0.00013 mgr. did definite harm. (4) Doses of 0.00002 mgr. were highly satisfactory. In her the interval of 14 days was satisfactory; the weekly interval was tried later, as certain instances in another case had suggested its use in preference to the 14 days' interval. She was to all appearances well when the weekly doses were tried and could not be said to have shown any evidence in favour of one interval more than the other, though it was, of course, while she was receiving fortnightly injections that her relief was obtained.

A second patient (G.H.) gave a positive von Pirquet reaction. He was a boy with persistently recurring, isolated styes, for which local treatment was possibly of some use during an attack, but proved quite useless in preventing recurrences. He came under observation first in June, 1916, and from then till October, 1918, he received the usual types of local treatment. In October, 1918, he was given his first injection of tuberculin T.R. 0.00002 mgr. and this was repeated every two weeks. He showed some improvement after the first injection and continued to improve until September, 1919, when he appeared practically well, getting only about one stye a month. The dose was then increased and was given weekly and he showed no reaction until he received a dose of 0.0002 mgr., when one lid flared up. He was put back on to 0.000005 mgr. weekly and things are well again. In a comparatively short period which has since elapsed, he has had no further styes.

In this case 0.00002 mgr. fortnightly was definitely useful, but did not quite effect a cure; 0.0002 mgr. was too large a dose and caused a fairly marked reaction, while 0.000005 mgr. seems to be holding the condition completely in check and is doing that while being given weekly.

The third patient (M.B.) was aged 30 years. There was a positive von Pirquet reaction. Hers was a very marked case, with much thickening of lids, lash deformity and skin involvement extending considerably beyond the margins. Local treatment was decidedly useful, but did not effect a cure. The trouble was of many years' standing when she was first seen. T.R. 0.00002 mgr. given fortnightly led to considerable improvement. When the dose was increased to 0.00005 mgr. fortnightly there was first some improvement, then the eyes got more irritable again and she was put back on to 0.00002 mgr. with further improvement. Later, she was put on to 0.00001 mgr. weekly and is now almost well. For some time past her treatment has consisted of *gutt. ac. boric.* and tuberculin injections and during the last two months it has consisted of tuberculin injections alone. She is well satisfied without any local treatment, as the results are speaking for themselves.

The improvement in this case suggested (1) that tuberculin T.R. was definitely useful; (2) that small doses, 0.00002 mgr. to 0.00001 mgr., even though she was an adult, were the most satisfactory; (3) that weekly injections were of greater use than fortnightly ones.

The last case to which I will refer, is one of the phlyctenular conjunctivitis, which was mentioned earlier. The patient definitely improves on T.R., but then relapses. At the present time she shows considerable promise, but I cannot forget that she has improved before and then fallen back again. She presents a problem which is not yet fully solved. I mentioned her case largely to illustrate the difficulties still to be faced. The work is incomplete and the conclusions drawn may yet prove to be erroneous.

These are the most interesting of a somewhat small number of instructive cases. Others have previously pointed out that failure in the use of tuberculin was due to its administering in excessive doses. I am trying to discover what is an excessive dose; so far it seems that 0.0001 mgr. must be classed as excessive. Whether tiny doses avoid all negative phase, or whether weekly intervals approach the right moment when the negative phase is over and the positive at its height, is not being argued here. It has seemed, however, that the clinical results were better when the interval was one week than they were on a fortnightly interval.

It is not suggested that fresh air and good feeding should be neglected, but one finds that these things are often to be classed as luxuries where hospital patients are concerned. These tiny doses of tuberculin seem useful, either as a partial substitute for or an auxiliary to other means. Further, I am quite satisfied that local treatment should, at any rate in the early stages, accompany the tuberculin. In the cases quoted above I do not think that the actual germ causing the lesion was the tubercle bacillus, but that the lowering of the patient's resistance to secondary invasions by the tubercular disease was probably an underlying factor. I have not so far tried combining other vaccines with tuberculin, nor have I used any other form of tuberculin than T.R.. The seat of inoculation has been the arm. Possibly, should my present methods fail, varying treatment from these points of view (an additional vaccine, another type of tuberculin, a different seat of inoculation) may effect a cure in my stubborn phlyctenular case, but I am hopeful that the difficulty will be solved when the proper sized dose of T.R. and the right interval have been determined.

It is suggested that (1) many, but not all, chronic cases of marginal blepharitis, including chronic recurring styes, have an underlying tubercular base; (2) tuberculin treatment is definitely useful; (3) tiny doses of T.R., 0.000005 mgr. to 0.00002 mgr., are those which give the best results; (4) the weekly

interval is probably more satisfactory than the fortnightly one.

This treatment has been studied entirely in relation to eye lesions, which present an unusual opportunity for observation, but I am hopeful that if its correctness can be more definitely demonstrated, the same lines may prove of some value in treating systemic tuberculosis.

Reports of Cases.

A NOTE ON THE TREATMENT OF IRREDUCIBLE INTUSSUSCEPTION IN CHILDREN.

A Successful Resection by Maunsell's Method.

By **Harold Rischbieth, M.A., M.D., B.Ch. (Cantab.), F.R.C.S. (Eng.),**

Honorary Surgeon to the Children's Hospital, Adelaide.

The treatment of irreducible intussusception in young children is a matter of great difficulty. This arises, not from the technique, for resection in children presents, on the whole, no more difficulty than in adults, but by reason of the fact that young children bear this operation exceedingly badly and recovery after it is very rare. Upon this point there will be a general agreement. There are only three cases of recovery after resection on record, as far as I can ascertain. The case that I am about to describe, therefore, appears to be of interest.

In the choice of an operation in this condition, two considerations outweigh all others, namely, brevity of time (or celerity) and the minimum of interference compatible with an efficient union. In these two respects Maunsell's method is, in my view, the best. Other more elaborate operations, technically more perfect, fail in practice, probably because they take longer to perform and inflict greater trauma in achieving their immediate object. Be this as it may, all the operations I have seen, performed, heard of or read about were unsuccessful, except the three above referred to. In one case, in which I performed resection, closure of the intestinal ends and lateral anastomosis, the child survived the post-operative shock and I anticipated a successful result. But it died suddenly on the sixth day, for reasons unknown, for autopsy revealed no cause of death; it was surmised that death was due to exhaustion, resulting from the trauma of the operation superadded to that of the intussusception itself. It appeared to me that this child would probably have recovered if an operation involving less trauma than a straight-out resection had been performed.

There has never been any succinct teaching upon this point, but I was determined, by reason of this melancholy instruction and experience, to employ Maunsell's method in any future case of irreducible intussusception that came under my care, because of its obvious advantages of simplicity, celerity and minimal interference with vital structures.

This is the narrative of the case:—

W.B., a boy, aged 4 years, was admitted to the Adelaide Children's Hospital from the country two days after the onset of vomiting, diarrhœa and abdominal pain. There was blood in the motions on the morning of admission.

On examination there was a good deal of shock, but the colour was good. There was resistance of the abdominal parietes and a doubtful tumour in the left iliac region. Nothing abnormal was felt *per rectum*.

Previous History.—The child had had attacks of colic intermittently for about six months previously.

Diagnosis.—Intussusception. An operation was performed immediately. The intussusception extended as far as the left pelvic brim. Reduction was performed slowly. The intussusception was reduced easily, until the tumour was about 6.25 cm. in length. After that, no further reduction was possible, owing to œdema and adhesions. Gentle compression produced no effect upon it. Then the peritoneal covering tore in three places. Resection by Maunsell's method was at once performed.

Subsequent History.—There was a singularly small amount of shock after this operation, if anything, less than before it; and recovery was uninterrupted.

Commentary.

Certain features of this case call for comment:—

(1) The age of this child (4 years) was considerably above the average for intussusception.

(2) Considering the exceeding gravity of the condition from which he was suffering, the general condition of the child before operation was remarkably good. The comparatively slight degree of shock and his good colour were remarkable features.

I have no doubt it was these factors, as much as the choice of the mode of operating, that determined the favourable result. I believe that this child might have recovered after the resection of the ordinary type. Therefore, for the purpose of adjudging the relative merits of one or another operative procedure in irreducible intussusception I do not think this case affords an altogether sound criterion, unfortunately. Nevertheless, for reasons already stated, it may be claimed that the Maunsell method, of all operative procedures, offers the best prospect of success in this condition.

Reviews.

THE TEACHING OF GYNÆCOLOGY.

Bethel Solomons' "Handbook of Gynæcology for Students and General Practitioners"[1] is an eminently practical production. In the preface he remarks: "I have always held that students of gynæcology require a small book to aid them in their practical work. If a volume of this size is read in conjunction with comprehensive teaching at a hospital, there is no need for further knowledge, except for the specialist." His book quite conforms with this dictum and as a student's book it should be eminently satisfactory, as long dissertations on subjects about which there is at present no concensus of opinion, are avoided or only mentioned incidentally, while the ordinary, every-day subjects are dealt with tersely and concisely. The reader gains the impression that the book is written by a man who knows his subject and knows how to impart its essentials to others.

The chapter on anatomy contains the usual details. The paragraph on the ligaments of the genital canal is sufficiently comprehensive to make the thinking student gain a better grasp of the subject of prolapse of the uterus than can be obtained from many of the larger text-books. There is a short paragraph on the embryology of the female pelvic organs, which should be helpful.

The chapter on the examination of the patient is concise and to the point and brings out all the essential features, while the necessity for a routine general examination of every patient who presents herself for gynæcological treatment, is duly emphasized.

At the end of the chapter on the disorders of menstruation a few useful prescriptions for the conditions described are added. Under the heading of inflammation are dealt with the conditions of vulvitis, vaginitis and endometritis and endocervicitis, with an account of the appropriate treatment for each.

Tumours of the genital canal are dealt with in the same way. In discussing the treatment of fibroids the author advocates the use of X-rays in certain selected cases, but his general advice on this subject coincides with that of Lockyer, in condemning this method of treatment.

In inoperable cases of malignant disease the use of radium is mentioned, as is the fact that the use of radium has in certain cases definitely caused what were considered inoperable cases to come under the heading of operable cases. Lacerations, malformations and displacements are described separately.

He notes that retroversions and retroflexions may cause no symptoms; in these cases the displacement should be left alone and the patient should not be told of its existence. This advice is eminently sound, as so many women concen-

[1] A Handbook of Gynæcology for the Student and General Practitioner, by Bethel Solomons, B.A., M.D., F.R.C.P.I.; 1919. London: Baillière, Tindall & Cox; Demy 8vo., pp. 236, with 106 illustrations. Price, 10s. net.

trate their attention on a displacement which is causing neither symptoms nor trouble. He insists on the fact that pessary treatment for the cure of retro-displacement is unsuccessful except in the early post-puerperal period and in old and debilitated patients unable to undergo operation. In all other circumstances he condemns pessary treatment.

Pathological conditions of the female genitalia which do not fall under the above headings are all treated in a separate chapter. They include *pruritus vulvæ*, gonorrhœa, syphilis, kraurosis, vaginismus and coccygodynia and also inflammatory conditions of the bladder and fistulæ. Under the same heading also is included sterility, one child sterility, constipation, obesity and, curiously, a paragraph on external hæmorrhage following operation.

The chapter on the use of gynæcological instruments contains a description of the usual gynæcological armentarium.

The remainder of the book, 50 pages out of a total of 230, is devoted to gynæcological operations. The descriptions are necessarily short, but are quite practical for all operations likely to be undertaken by the general practitioner. Dudley's method of operating in complete laceration of the perineum is not mentioned, though this operation is simpler than the method described. A short description of Wertheim's operation for carcinoma of the cervix is given, mention being made of the fact that some authorities advise the use of bismuth-iodoform-paraffin paste for the extensive raw surfaces left after this operation. He describes the operation of dilatation of the Fallopian tubes with air in cases of sterility, which he practises in certain cases.

There are numerous illustrations, practical and helpful from a student's point of view. Altogether the book can confidently be recommended as one of the best text-books for a student preparing for an examination.

THE CASE OF DR. EUGENE HIRSCHFELD.

The Council of the Queensland Branch of the British Medical Association has addressed the following resolution to the Prime Minister, Colonel Cameron and General Sir W. Glasgow:—

> The Council of the Queensland Branch of the British Medical Association has learned with astonishment and regret that Dr. E. Hirschfeld has been released from internment. Further, the Council wishes to reiterate its opinion that Dr. Hirschfeld should be deported from the Commonwealth of Australia.

It is with regret that we learn of the death of Dr. Frederick John Elliott, of Derby, Western Australia.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the eight weeks ending December 27, 1919:—

	Metropolitan Combined District. Cs.	Dths.	Hunter River Combined District. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	30	8	15	0	74	5	119	13
Scarlatina	101	0	2	0	49	0	152	0
Diphtheria	138	2	23	0	193	5	354	7
*Pul. Tuberculosis	177	78	15	3	19	4	211	85
C'bro-Sp'l Menin.	1	2	1	1	0	0	2	3
Poliomyelitis	2	0	0	0	0	0	2	0
Malaria	5	0	0	0	2	0	7	0

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the seven weeks ending December 21, 1919:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total Cs.	Dths.
Enteric Fever	4	0	30	0	34	0
Scarlatina	120	4	98	2	218	6
Diphtheria	321	5	217	8	538	13
Pulmonary Tuberculosis	108	56	44	22	152	78
C'bro-Spinal Meningitis	3	1	0	0	3	1
Poliomyelitis	1	0	0	0	1	0
Puerperal Fever	3	0	1	0	4	0

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the eight weeks ending December 27, 1919:—

Diseases.	No. of Cases.
Enteric Fever	108
Scarlatina	23
Diphtheria	300
Pulmonary Tuberculosis	55
Poliomyelitis	1
Erysipelas	15
Anchylostomiasis	1
Puerperal Fever	3
Pneumonia	31
Influenza	152
Cerebro-Spinal Meningitis	2

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the nine weeks ending January 3, 1920:—

	Adelaide. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	2	0	16	3	18	3
Scarlatina	16	2	168	1	184	3
Diphtheria	12	1	123	6	135	7
Pulmonary Tuberculosis	11	14	67	36	78	50
Erysipelas	0	0	5	1	5	1
Morbilli	150	1	1682	3	1832	4
Pertussis	4	0	71	2	75	2
C'bro-Spinal Meningitis	0	0	2	1	2	1
Puerperal Fever	0	0	3	0	3	0
Influenza	5	1	138	11	143	12

WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the months of November and December, 1919:—

	Metropolitan. Cases.	Rest of State. Cases.	Total. Cases.
Enteric Fever	9	5	14
Scarlatina	31	20	51
Diphtheria	67	39	106
Pulmonary Tuberculosis	47	32	79
Malaria	14	4	18
Beri-beri	0	1	1
Erysipelas	7	4	11
Ophthalmia	0	1	1
Dengue Fever	0	2	2
Influenza	121	192	313

TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the eight weeks ending December 27, 1919:—

Diseases.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Enteric Fever	3	3	14	20
Scarlatina	0	2	0	2
Diphtheria	6	27	48	81
Pulmonary Tuberculosis	13	4	8	25
Ophthalmia Neonatorum	0	1	0	1
Puerperal Fever	0	0	2	2
Influenza	0	8	184	192

The Medical Journal of Australia.

SATURDAY, FEBRUARY 7, 1920.

The Medical Act of South Australia.

Parliament in South Australia has recently modified the law regarding the registration of medical practitioners in the State. The measure was considered carefully and each clause containing provisions of a novel or unusual character was debated at sufficient length to enable the members to form an intelligent opinion of its significance. There was no unseemly pressing of the measure through by the responsible Ministers. From the summary of the debates in both Houses, published in this issue, it will be seen that the Chief Secretary and the Treasurer recognize the important functions of the medical profession and are anxious to co-operate with the medical profession in promoting the health of the public. The Ministers refused to be influenced by references to an old and unfortunate disagreement between a previous Government and the medical profession. The British Medical Association was referred to in the debate as the representative organization of the medical profession, an organization toward which the Government obviously entertains friendly feelings. By the wise exercise of its functions, the South Australian Branch of the British Medical Association has demonstrated to the Parliament of the State that its primary concern is the bodily and mental welfare of the people.

Hitherto the legislation governing medical registration in South Australia has been unsatisfactory. There were three measures in force, Ordinance No. 17 of 1844, the *Medical Act* of 1880 and the *Medical Act Amendment Act* of 1889. The new Act gives the medical profession and the University of Adelaide one representative each on the Medical Board. Previously all the members were nominated and appointed by the Governor. In the new Board the Government representatives number three out of five. In the Bill the proposal was to give the Government and the medical profession two representatives each and the University one. The duties and powers of the Board have been modified to some extent. Under the old Acts the Board was required to register an applicant for registration, provided he produced evidence of the prescribed qualifications. The Board was further empowered to remove from the register the name of a medical practitioner who had been convicted of a felony or misdemeanour or whose qaulifications had been cancelled. Under the provisions of the new Act the Board has more discretion in regard to the registration of applicants. The decisions of the Board, however, may be challenged by appeal to the Supreme Court. The Board cannot remove the name of a medical practitioner, but may apply by motion to the Supreme Court for the removal of a name. The name may be removed in this manner if it can be shown that the registration has been obtained by fraud or misrepresentation, if the qualification has been withdrawn or if the name of the practitioner has been removed from the medical register of the United Kingdom, if the person has been convicted of a felony or misdemeanour or if he "is deemed by the Board to have been guilty of infamous conduct in any professional respect." Moreover, the Act provides a penalty for falsifying the register or for making false statements or uttering or putting off false or forged or counterfeit diplomas, etc.. These acts constitute a misdemeanour and consequently the person involved would be struck off the register, besides having to serve a term of imprisonment. This provision is an important one, inasmuch as the registration in virtue of a bogus certificate or diploma would *ipso facto* constitute a misdemeanour, apart from the question of fraudulent intention. Of vital importance to the status of the medical profession is the amendment of the law in regard to the qualifications entitling to registration. Under the old Acts any one who had completed a four years' course in any country and had obtained a degree or diploma equal in the opinion of the Medical Board to the qualifications entitling the holder to be registered in the United Kingdom, could be registered. In practice, this led to the recognition of a heterogeneous accumulation of registerable degrees and diplomas. Under the new Act medical graduates of our Australian and of the New Zealand Universities, persons entitled to registration in the United Kingdom and

persons entitled to practise as medical practitioners in a foreign country which has entered into reciprocal arrangements with South Australia, are entitled to become registered. In the latter case the practitioner must have passed through a course of study of not less than five years' duration and of equal standard to that prescribed by the University of Adelaide. For the present the qualifications required in South Australia are the Australasian degrees and the qualifications entitling the holders to registration in the United Kingdom.

Previously a fee for registration of one guinea was charged. Now there is an annual registration fee of the same amount, but practitioners may pay the sum of five guineas for perpetual registration. Those who were registered under the old Acts are exempted. The medical profession obtains some protection by the prohibition of all persons other than registered medical practitioners to sue for fees for professional services. No one other than a medical practitioner may hold the position of a medical officer at a public hospital, the position of a medical officer of health or the position of a medical officer on any vessel. Penalties are provided in the case of unregistered persons advertising themselves as, or pretending to be, medical practitioners. In addition, the provision contained in the old Acts, prohibiting an unregistered person from signing a death certificate, except when there is neither a coroner nor a medical practitioner within a distance of five miles of the place where the death has occurred, is preserved. It will be interesting to watch the effect of these protective clauses. It will be noted that unqualified practice is not rendered illegal, but if the unregistered individual makes the mistake of using some designation indicating that he is a medical practitioner, a doctor, accoucheur or surgeon, he comes within the arm of the law.

One clause was removed during the passage of the measure through Parliament. It contained the provision for the payment of a fee to the members for attendance at the meetings of the Medical Board. It is difficult to understand why objection was taken to this clause, since the total amount of money involved was small, not exceeding £76 a year, and since even this small sum would not be provided out of consolidated revenue. In all other respects the new law is admirable and marks a further step toward the attainment of uniformity of the registration legislation in the Commonwealth.

THE AUDITORY APPARATUS IN FLYING.

The problems associated with flying demanded immediate and direct attention during the currency of the war. Apart from the desire to overcome the causes of accident, the military value of the Air Force Unit depended on the capability of pilots to perform the necessary evolutions in the air to enable observations to be made and to prevent the enemy airman from using the air as a point of vantage. Many of the mechanical defects of pre-war machines were eliminated and the risk of crashing from purely constructional causes was reduced to a minimum. Physiologists were asked to determine as far as science permitted those causes of disaster that were traceable to defects in the human being. In these studies the Air Medical Investigation Committee, working under the auspices of the Medical Research Committee, attacked and solved many difficult problems. The neurologists were called upon to ascertain whether stability in air could be guaranteed by a careful selection of suitable men and the exclusion of those unsuited to flying in high altitudes or in uncertain meteorological conditions. In the next place the otologist was approached with the task of tracing the cause of certain untoward symptoms commonly experienced, even by experienced airmen. An interesting contribution to this study has been published in the Special Report Series of the Medical Research Committee by Mr. Sydney Scott.[1] He found on examining a large number of flying men in France that immediately on landing many complained of deafness, pain in the ears or discomfort, headache, dizziness, nausea, faintness or vomiting. These symptoms were frequent after a rapid descent from a high altitude. It was seen that the tympanum in extreme cases was sucked into the tympanic cavity and lay closely folded around the neck and handle of the malleus, the short process of the incus and the incudo-stapedial joint. The *membrana tympani* itself was often found to be intensely hyperæmic and globules of mucus were seen through the invaginated membrane in the middle ear cavity. Mr. Scott explains this sucking in of the membrane as a failure of the Eustachian tube to open during the course of the descent. He reminds his readers that if an airman ascends to a height of 18,000 feet and his Eustachian tubes are opened at regular intervals during the ascent, the pressure within the tympanic cavities will be 400 mm. Hg. at the moment of turning. A rapid descent is often accomplished without a re-opening of the Eustachian tube. By the time the airman reaches ground, the pressure outside his *membrana tympani* is 350 mm. in excess of the pressure within the cavity. At times the pharynx and Eustachian tubes are hyperæmic or swollen as a result of a cold. Airmen often keep their mouths open during flying, especially when fighting and diving. The mouth becomes parched and swallowing becomes painful, difficult or even impossible. In his own case,

[1] The Ear in Relation to Certain Disabilities in Flying; Report of the Air Medical Investigation Committee, Medical Research Committee, National Health Insurance, Special Report Series, No. 37, 1919.

Mr. Scott found that it was by no means easy to open his Eustachian tubes during a rapid descent and he succeeded only when the attempts were made deliberately and after practice. Experimentally he found that different individuals tolerated very different degrees of excess pressure applied to the external face of the tympanic membrane. Some complained of pain when the pressure equivalent to 140 mm. of mercury was exerted; others tolerated a pressure of 280 mm. The results of his observations were striking. Air Force officers who suffered acutely on landing after high flights, were taught to inflate their tympanic cavities during the descent and the deafness and other auditory trouble disappeared once and for all time. It is not suggested that all auditory defects during flying are due to closure of the Eustachian tubes. Cases of so-called nerve deafness associated with vertigo and air-sickness are recounted in which complete relief was ultimately achieved by inflation of the tympanum. But when there was persistent ear trouble, it became necessary to recommend the airman's discharge. On the other hand, Mr. Scott maintains that airmen with old *otitis media* and ruptured *tympani* were frequently exempt from all disturbing symptoms during high flights. He learned that the vestibular tests were of small value in ascertaining the suitability of candidates for the air service. Some experienced airmen obviously were not dependent on the functional activity of their semicircular canals for a proper recognition of their position in space. These men lost this sense when flying in dense clouds.

SLEEP.

The subject of sleep has been dealt with by countless authors. The greater part of the literature which has arisen from the earliest times up to the present, has no scientific interest. Men have guessed the significance of sleep, have imagined the nature of the condition and have built up on insecure foundations theories concerning subconscious mental activity belonging to the world of metaphysics. A small part of the literature is devoted to physiological observations. Nearly all the facts accumulated in connexion with this subject have been discovered within recent times. It is therefore necessary, when endeavouring to fathom the mysteries of the condition in which man spends one-third of his life, to disregard all the superstitions and fancies which have gathered around it in the course of centuries. In an excellent address delivered before the Dublin University Biological Association, Mr. E. H. Allen has collected and summarized the main facts concerning sleep.[1] He prefaces his physiological remarks with a statement that it is a period of anabolism, repair and growth, during which the organism fits itself for renewed activity. He does not completely justify this assumption. In the first place, metabolism is slowed, but not arrested. The amount of oxygen consumed is diminished and the quantity of carbon dioxide produced and removed is reduced. Many physiologists have endeavoured to ascertain the nature of the change in the distribution of the blood when a person passes into a condition of sleep. Measurements by Mosso's plethysmograph tend to reveal that the limbs enlarge in response to a dilation of the peripheral vessels. Mosso's classical experiment reveals that the circulation in the brain is slowed and restricted, with a consequent diminution in the weight and size of the brain. Durham proved sixty years ago that sleep is accompanied by a cerebral anæmia. The blood pressure is said to fall during the first two hours of sleep and then to rise gradually until the person awakes. Similarly, there is evidence of a reduction of tissue metabolism in the internal organs, following a lessened blood supply and a slower rate of movement of blood in the vessels. It is, however, well known that digestion continues during sleep. The renal excretion is at times as active during sleep as during waking, although this is not the rule. The sweat glands in the skin reveal increased activity, owing to the hyperæmia of the cutaneous regions of the body. It may therefore be concluded that sleep is not actually a period of anabolism, but of modified metabolism. That tissue repair proceeds during sleep is highly probable, although direct observations are wanting. The third proposition, that sleep is the period of growth, is a hazardous one. Mr. Allen does not adduce a single fact in its support. Growth apparently continues at its normal rate during waking, although there is some evidence that it is accelerated during periods of prolonged resting. The condition of the nervous system during sleep has been examined by many physiologists. It is agreed that reflex excitability is weakened during quiet sleep. Usually the voluntary muscles are relaxed, but, as Mr. Allen points out, normal muscular activity may be exhibited during sleep. It has been demonstrated that external stimuli produce a normal, albeit lessened, response. Dreams indicate cerebral activity, with the possibility of normal associations. Purkinje has suggested that sleep is due to the cutting off of nerve paths between the brain and the periphery by a cerebral congestion. Careful study, however, has failed to produce any evidence in support of such a phenomenon. Similarly, Osborne postulated an increased secretion of cerebro-spinal fluid from the arachnoid plexus and a consequent distension of the ventricles. The existence of an increased quantity of fluid in the ventricles has not been demonstrated. It thus appears that our information concerning the changes in the central nervous system during sleep are scanty and quite incomplete. It is useless speculation to adduce theories of sleep when the facts have not yet been collected. Mr. Allen reviews the vasomotor and chemical theories, particularly those associated with the names of Weir-Mitchell, Hammond, Preyer, Pflüger and Errera and the so-called histological theory of Ramon y Cajal and finds them all wanting in convincing argument. The psychologists would have us satisfied with a conception of sleep based on the assumption of the elimination of the full consciousness of the individual. They have no acceptable information concerning the mechanism governing the removal of consciousness. It is quite easy to state that in sleep the subconsciousness of the individual is left untramelled and uncontrolled by will and superconsciousness. The physiology of sleep is not understood and will remain an unsolved problem until the physical and chemical phenomena have been exhaustively studied.

[1] *The Dublin Journal of Medical Science*, August-September, 1919.

Abstracts from Current Medical Literature.

SURGERY.

(46) Omental Grafts.

Investigations into the value of omental grafts in abdominal surgery are recorded by W. L. Finton and M. M. Peet (*Surg., Gynec. and Obstet.*, September, 1919). Detached omentum survived under sterile conditions when applied to any abdominal organ. The size of the graft made no difference, but its thickness was of importance. Thin grafts survived more easily and gathered fewer adhesions. Mechanical irritation of the peritoneal layer, in which the graft is laid, is not necessary, while hæmorrhage under the graft impaired its chances. Plain fine silk seemed the best suture material and sutures must be placed at least at the four corners. Detached grafts survived when employed to reinforce Lembert sutures, provided infection was kept at a minimum, but when used to close small punctures they acted more as mechanical patches than as living grafts, for they underwent marked changes and were the seat of dense adhesions. Vaseline and paraffin increased these adhesions and saline solution was useless in preventing them. Grafts were found valuable in replacing lost peritoneum, strengthening suture lines, covering the stump of the cystic duct and reinforcing the peritoneum when perforation was threatened. In the presence of peritonitis, detached grafts do not survive, but they may be used as a mechanical plug till adhesions form. The piece of graft should be from the free border of the great omentum.

(47) The Surgical Aspect of Malaria.

The importance of considering malaria in the diagnosis of surgical cases is dealt with by Marguerite White (*Lancet*, July 26, 1919), who refers to cases of pseudo-appendicitis and pseudo-cholecystitis which have cleared up under intramuscular injections of quinine. The sub-tertian or malignant type is the most important in conditions which come under the surgeon's notice. The suggestion is put forward in explanation why an operation so frequently precipitates an attack is that the trauma of operation weakens the antitoxic mechanism which is restraining the plasmodium from invading the circulation. Delayed wound healing is frequent in cases of latent malaria; the granulations are unhealthy and some of the wounds resemble syphilitic sores. After a gunshot wound in the head symptoms sometimes arise suggesting cerebral abscess, but under quinine therapy the symptoms disappear. So widespread is the effect of malaria and so long may it lie latent that no surgical diagnosis in the case of a patient who has been in a malarial district, should be made without a careful consideration of the possible presence of malaria. A negative history and the absence of parasites in the blood do not exclude the possibility of the disease being present.

(48) Internal Derangement of the Knee.

Gordon Watson (*Clin. Journ.*, October, 1919) points out that tears of a semilunar cartilage, according to experimental evidence, occur most easily during the final stage of extension, whereas clinical evidence shows it most likely to happen when the leg is partially flexed, abducted and rotated outwards. In about half the cases the tear is longitudinal and the longitudinal tear may involve the anterior part only, the whole cartilage or the posterior portion. The external cartilage is affected in only 10% of the cases. The usual clinical history is of severe pain with locking followed by swelling. Sometimes a crack is heard at the time. Recurrence from trival causes is common and in the interval there is freedom from symptoms. The more chronic the condition, the less severe is the pain. The diagnosis depends largely on the history. In long-standing cases, relaxation of the internal lateral ligament and thickening of the synovial membrane may be detected. Nipping of the synovial fringes is distinguished by the symptoms being less marked and by a history of chronic disease. Locking from loose bodies may simulate injury to a cartilage, but at some time or other these may be located in a superficial position; the diagnosis can be confirmed by skiagram. Injury to the crucial ligaments and fracture of the tibial spine are always the result of severe violence. If the anterior crucial ligament is torn, while the posterior remains intact, the tibia in the extended position can be made to slide forward on the femur, while if the posterior is torn and the anterior intact, the tibia can be pushed backward on the femur without flexion.

(49) Permanent Colostomies.

The method of performing colostomies at the Mayo Clinic is described by W. E. Sistrunk (*Surg., Gynec. and Obstet.*, May, 1919). A vertical incision is made 2.5 cm. below and to the left of the umbilicus, which permits a good exploration of the abdomen. A loop of the sigmoid flexure is taken and an incision 4 to 5 cm. made in the mesentery parallel to the line of the vessels and extending nearly to the bowel. A second incision, 2 cm. long, is made at right angles to the first, at the intestinal border. Two strips of gauze are pushed through this T-shaped incision, and when they are drawn apart a wide opening is made to gape in the mesentery. The two sides of the abdominal wall near the centre of the abdominal incision are sutured together through this opening. The remainder of the abdominal wall is sutured together in the usual way, except that the bowel is included in the nearest suture to prevent herniation; the gauze is removed and a glass rod substituted. The bowel is opened by cautery five or six days later, but may be punctured to relieve gas any time after the first twenty-four hours.

(50) Cranioplasty.

Janssen (*Ambulance de l'Océan*, July, 1918) holds that the thorough suppression of cutaneo-meningeal and meningo-cerebral adhesions is of great importance in cranioplasty. Too frequently merely an æsthetic effect is sought, consequently it is not fair to judge the results of the operation as a whole, unless details of the technique used are available. Pierre Marie is quoted as having examined 21 men who had been submitted to operation, and of these six showed complete disappearance of subjective symptoms; in three the symptoms were aggravated and in 12 the condition was stationary. Janssen gives details of 16 cases in which cartilage grafts were used and 20 in which bone was employed. He prefers the latter method, following the technique of Delagenière. The cicatrix is widely removed, and if there is meningeal loss, a strip of *fascia lata* is used. The periosteal side of the graft should be toward the brain and should be inserted between the pericranium and the external table without accessory catgut fixation.

(51) Polyposis of the Stomach.

The first case of polyposis of the stomach that has occurred in 69,000 abdominal sections at the Mayo Clinic is recorded by D. C. Balfour (*Surg., Gynec. and Obstet.*, May, 1919). The patient, a man, aged 31, complained of anorexia for the previous five years and for the last three years pain when the stomach was empty. The test meal showed an absence of free HCl., but on X-ray examination a diffuse mottled appearance, sharply limited by the pylorus, was seen. Resection of about two-fifths of the stomach was performed and continuity established by the anti-colic side-to-end anastomosis. Examination showed the tumour corresponded to the *polyadenomes polypeux* of French writers. There was no hyperplasia of gland elements and no suggestion of malignancy. This condition should not be confused with single polyps or with papillomatous masses, the latter being usually malignant.

(52) Hæmatogenous (Idiopathic) Peritonitis.

In reviewing the subject of hæmatogenous peritonitis W. H. Battle points out (*Clin. Journ.*, October, 1919) that the pneumococcus is the most common cause of the condition. Of 78 cases of peritonitis at St. Thomas' Hospital due to unknown origin, 31 were due to the pneumococcus and 18 to the streptococcus. There are three types of pneumococcic peritonitis—an acute form (an abdominal case from the beginning), a form in which the abdominal and the chest conditions are simultaneous and a chronic septicæmic form. Of the 18 patients with streptococcic peritonitis 6 recovered. Eleven of them were under 10 years of age. *B. pyocyaneus* causes a very malignant form of infection. There remains a large group in which the cause remains doubtful. Sometimes the fluid is found on examination to be sterile. He emphasizes the importance of early operation to prevent the toxæmia caused by re-absorption from the peritoneal cavity.

GYNÆCOLOGY AND OBSTETRICS.

(53) Physiology and Pathology of the Endometrium.

Lawrence W. Strong (*New York State Med. Journ.*, August, 1919) states that within the last ten years the most noticeable advance has been in the correlation of the various stages of the *corpus luteum* with those of the uterine mucosa. Ovulation normally occurs from the sixteenth to the nineteenth day after the onset of menstruation and a fresh *corpus luteum* is always present in the premenstrual stage of the endometrium. The secretory stage of the uterine mucosa is identical with the premenstrual and marks the development of the *corpus luteum*. During this stage mucin is discharged from the gland cells of the mucosa; mucus is very scanty or absent in the proliferative or internal stage of the mucosa. He has not been able to convince himself of the presence of glycogen in the gland cells during the secretory stage and he questions the presence of a tryptic ferment during the same stage. In three cases the removal of the *corpus luteum verum* during the second month has had no effect on the pregnancy. All lutein tissue, however, undergoes hypertrophy during pregnancy and the function of the *corpus luteum verum* may have been supplied by older bodies in these cases. The relationship between the sexual gland hormones and those of the other accessory glands of internal secretion are too complex for any simple explanation of the menstrual function. The mucosa of uteri removed by hysterectomy does not manifest both the proliferating and the secretory stages at the same time. Leucocytes emigrate during the secretory stage and are most numerous during menstruation. Unless they are focal in minute abscesses, they are not pathological. He questions the theory of Schroeder that there is complete destruction of the functioning layer normally during menstruation, as he has found evidence of chronic fibroblastic changes in the stroma. The signs of inflammation in the uterine mucosa are masked by the normal physiological exudation of leucocytes, round and plasma cells. All the glandular variations and stromal changes, formerly described as endometritis, are now recognized as cyclic changes. Endometritis is practically always bacterial in origin and is chiefly puerperal or gonorrhœal. Hyperplasia is the simplest and commonest expression of non-specific pathological change which occurs in the endometrium. It shows itself as an exaggeration of the normal and it may be said that the proliferative stage passes insensibly into hyperplasia. As far as histological appearance goes, hyperplasia passes without definite boundary line into the picture of adenoma and also into the picture of carcinoma. The general conclusion from the examination of many specimens obtained by curettage is that the uterine mucosa is very resistant to pathological change. Simple, uncomplicated endometritis is seldom encountered and it cannot be a frequent cause of the common disorders of menstruation. Irregularities and hæmorrhage are much more frequently due to adnexal disease.

(54) The Treatment of Placenta Prævia by Conservative Methods.

George W. Kosmah (*Surg., Gynec. and Obstet.*, December, 1919) considers that in primiparæ with a rigid cervix and a central *placenta prævia*, the child being near full term and still in good condition, Cæsarian section offers the best method of delivering for both mother and child. It will be found, however, that in the large majority of cases the implantation is not central, so that hæmorrhage of any extent usually results only after the cervix has become thoroughly soft and is dilating. *Placenta prævia* usually occurs in multiparæ. It must be borne in mind that it is essential to bring about gradual dilatation of the cervix to reduce the possibility of hæmorrhage as much as possible and to avoid infection. Control of the hæmorrhage during dilatation is the important indication and he believes that this can be more effectively done by extra-ovular introduction of the Voorhees bag. The bag can usually be introduced without an anæsthetic. Whilst it is being inflated two fingers are introduced into the vagina to prevent the bag from slipping out of the cervix. After complete distension the stem is placed within the vagina. Vaginal examination every two hours is recommended to ascertain if the bag has been expelled; bleeding often indicates expulsion. Rapid delivery is usualy contraindicated, as it results in deep cervical lacerations, with consequent dangerous hæmorrhage. After delivery of the child he recommends immediate expression of the placenta followed by the use of pituitrin or ergot. He has used this method in ten cases and promises to give further results in a later article.

(55) Ovarian Residue.

William P. Graves (*Surg., Gynec. and Obstet*, December, 1919) states that when ovarian extract is used mainly for the relief of symptoms, no scientific accuracy can be claimed. Reliable preparations are difficult to secure, as the material readily decomposes. He has made use of the ovarian residue, which remains after ablation of the *corpus luteum*, which is used in making *corpus luteum* extracts. He states that *corpus luteum* extract is very prone to cause intestinal disturbance, probably as a result of decomposition and that he has had little or no similar trouble when using the ovarian residue. There is good evidence that in the process of growth, at least, the theca luteal cells of the atretic follicles are important agents in the manufacture of the ovarian internal secretion. Using the ovarian residue he has endeavoured to get glands from pregnant animals, as follicle atresia is more active during pregnancy. He has a series of cases treated with whole ovary, ovarian residue and *corpus luteum*. The results with the first two are similar, but he is inclined to favour the residue. *Corpus luteum* has not given such good results. He appends the results in three groups: (*i.*) those exhibiting symptoms of the natural or artificial menopause; (*ii.*) those treated for such menstrual disturbances as amenorrhœa, oligomenorrhœa, delayed menses and clotting; (*iii.*) those of essential dysmenorrhœa.

(56) Sacral Suspension of the Uterus.

John Van Doren Young (*Surg., Gynec. and Obstet.*, September, 1919) states that there is a normal position of the uterus and there are variations that are within physiological limits, but there is a point beyond which lies the area of pathology. He draws attention to the importance of examining a woman in both the dorsal and erect positions in judging of the importance of a retroversion, of the degree of *descensus* and of the result of an operation. Skeletal poise is of importance, but correction of faulty poise cannot shorten ligaments that are stretched beyond their elastic limit. Birth trauma is of the greatest importance as a contributory cause in retroversion and *descensus*. In pathological mechanical retroversion the fundus is below the promontory of the sacrum, the cervix impinges on the trigone and the fundus of the bladder is pulled back by the uterus. The vagina is shortened, the upper portion displaced forwards in the pelvis and it becomes perpendicular when the patient is standing. The venous return is impeded both by the twisting of the broad ligaments and by the infundibulo-pelvic ligaments being dragged over the edge of the true pelvis. In cases of *descensus* retroversion may be present beforehand or the two processes may be synchronous. Both are due to marked yielding of the utero-sacral swing, which places the axis of the uterus in the axis of the birth canal and allows intra-abdominal pressure to have a greater effect. He instances cases with pronounced backache; in these, in the dorsal position the uterus seemed normal in position, but in the erect position well marked *descensus* was present. Treatment is divided into general, local, pessary and operative. Pessaries are of use where operation is contra-indicated and also in post-partum cases. In cases with marked birth trauma the vaginal and perineal repair work is done and a week or two later the abdomen is opened and the utero-sacral and round ligaments shortened. In the operation of sacral suspension, the utero-sacral ligaments are reduplicated to such an extent that two fingers can easily be passed between the ligaments behind the uterus. The round ligaments are shortened, either by the Alexander operation or by a modification of the Gilliam operation. The author has performed the operation of sacral suspension in 280 cases and states that labours after the operation have been most satisfactory.

Medical Matters in Parliament.

THE MEDICAL PRACTITIONERS' ACT, 1919, SOUTH AUSTRALIA.

The Chief Secretary introduced into the Legislative Council of South Australia on September 1, 1919, a bill to amend the existing law governing the registration of medical practitioners in the State. On September 23, 1919, he moved the second reading. He pointed out that this Bill had been considered in the Legislative Council in 1913 and had been passed with some minor amendments. It had been read for the first time in the Legislative Assembly, but had not secured a second reading. He sketched the provisions of the measure in a short speech and commended the measure as one which would prove to supply a want that had been acutely felt by the medical profession and also by the general public. The Honourable J. Jelley announced that he would support the second reading, but that he would move certain amendments in the Committee stage to improve the measure. He thought that the Bill, as it stood, would have the effect of making members of the medical profession in South Australia a closer corporation, if possible, than they were. He had no objection to a medical bill which would safeguard the public from being fleeced by people who ought to know something about medicine and, in many cases, knew nothing about it. In discussing the general principle of requiring evidence of a five years' course from an applicant for registration, he pointed out that five years was too long a period. In his opinion no obstacle should be placed in the way of any man adopting the medical profession. Opportunities should be given for men to qualify at the earliest moment possible. He maintained that people had gone down to their graves at an early age because they were not able to afford to pay the exorbitant charges made by the medical profession.

The Honourable W. Hannaford supported the second reading. He stated that they had come to the stage in connexion with affairs affecting the public health when they were beginning to feel that the medical profession could possibly do more than they were doing for the prevention of disease. He advised a plan of securing the services of men of exceptional ability for the purpose of investigating some of the diseases that were too often encountered.

The debate closed with a short speech by the Honourable J. H. Cooke on the question of the reciprocity clause. The Bill was read for the second time.

The Committee stage in the Legislative Council started on September 25, 1919, and was concluded on October 1, 1919. The first amendment proposed was in connexion with Clause 5, which deals with the constitution of the Medical Board. The Honourable J. Jelley objected to the proposal that the Minister should nominate two members of the Board, that the registered medical practitioners resident in the State should nominate two and that the University should nominate the fifth member. He moved a long amendment to cover all the clauses included in Part II. of the Bill. The Governor should, he thought, appoint a board consisting of not less than three nor more than seven members. He claimed that the whole of the Medical Board had been appointed by the Government under the Act of 1844. The same applied to the New Zealand Act. He objected to delegate to a private body powers that could be used arbitrarily. The Board should be amenable to the will of Parliament. He referred to the experience of Parliament during the reign of Henry VIII., when a measure, introduced to legalize a distinction between physicians and doctors of medicine, had to be repealed because of the effect the measure had on the attendance accorded to the poorer section of the community.

The Chief Secretary described the amendments suggested by Mr. Jelley as a very drastic method of getting over certain difficulties. He indicated the defects of the recasting of the second part of the Bill. The amendment was lost by four votes to fifteen.

The Honourable H. Tassie moved to amend Clause 7. The Clause read as follows:—

> 7. No person shall be eligible for appointment as a member unless at the time of nomination such person is registered under this Act, and, if the nomination is made after the expiration of the period of five years from the passing of this Act, he has been so registered for not less than five years.

The amendment was to the effect that the words "if the nomination . . . . of this Act" be deleted as well as the word "so" and that the words "thereunder or under the Acts hereby repealed" be inserted after the word "registered" in the last line but one. The object of the amendment was to make it clear that a period of five years should elapse after registration before a person would be eligible for appointment. The Chief Secretary pointed out that if the amendment were accepted, a practitioner who had been registered for four years under the repealed Act and four years under the new Act, making a total period of eight years, he would not be eligible. He promised to submit the matter to the Parliamentary draftsman and to re-commit the clause at a later date. This course was accepted.

Clause 13 provided fees for attendance at the meetings of the Medical Board. The members were to receive one guinea for each attendance and the Chairman two guineas, provided that the fees were restricted to twelve meetings in any one financial year. The Honourable F. S. Wallis thought that the claim for payment for attendance of members of the Medical Board should be waived. As far as he was aware, the medical profession had not asked for this payment. He said that if there were one man who should be paid for his services, it was the Chairman of the Adelaide Hospital Board. The duties attaching to this post made a great inroad into the Chairman's time. The Chief Secretary pointed out that the amount involved was small, but that it embodied a principle. After a short debate the clause was negatived.

Clause 17, which became Clause 16 by the deletion of the clause mentioned, read as follows:—

> 16. (1) The Registrar shall every year, in the month of July, prepare a balance sheet, showing the income and expenditure of the Board for the period of twelve months ended on the thirtieth day of the preceding month of June and shall transmit the same to the Minister.
>
> (2) The accounts of the Board may, once at least in every year, be audited by the Commissioner of Audit, who shall, in respect of such accounts, have all the powers which may be exercised by him under the Audit Act, 1882, and any Act for the time being in force relating to the audit of public accounts. The report of such Commissioner on any such audit shall be transmitted to the Minister.

The Honourable F. S. Wallis moved that the word "may" in the second sub-clause be struck out and the word "shall" be inserted in its stead. The amendment was accepted and the clause as amended was adopted.

Clause 19, dealing with the qualifications for registration, was passed unamended, after the Honourable J. Jelley had protested against the expression: "proves to the satisfaction of the Board." He considered that the satisfaction of the Board was not needed, when the person applying for registration was able to prove that he was entitled to registration.

The same member wanted to alter the wording of the following clause, dealing with the attendance before the Board of persons applying for registration. His attention was called to the provision in the clause giving the Board discretion. The amendment was withdrawn. He moved a further amendment to the same clause, sub-clause (5), with the object of removing the discretion of the Board in connexion with the refusal to register. The amendment did not receive support.

The Honourable J. Jelley next endeavoured to strike out that portion of Clause 31 which prevents any person other than a registered medical practitioner from sueing for the recovery of fees for medical or surgical advice, attendance, service or operation. He sought to show that the clause as it stood would prevent a masseur or a Christian scientist from recovering fees for services. He quoted the law of Kentucky, Illinois and Nebraska in support of his contention. The Chief Secretary maintained that the clause would not interfere with the practice of a masseur or of a nurse. He stated that the provision was contained in the Act during the past 40 years. No difficulty had arisen. The Honourable J. H. Cooke feared that the clause might impose hardship on persons who rendered valuable services to the community. He was not satisfied that it would not prevent

dentists from recovering fees. The Honourable T. Pascoe suggested that the clause might affect a nurse who was acting in a country district under the doctor's orders. The Honourable W. G. J. Mills held that many persons rendered great assistance in country districts in the absence of a medical practitioner and he thought that those services should be recognized. The Chief Secretary promised to consult legal and medical opinion and if it were found that hardship would be entailed by the retention of the clause in its present form, he would have it recommitted.

Attention was drawn to a possible difficulty in applying the provisions of Clause 32, which requires all persons acting as medical officers in public hospitals or as officers of health to be registered medical practitioners. The Honourable F. S. Wallis conceived that it might be impossible to secure the services of a qualified medical man for some hospital positions. Students had been allowed to occupy these posts shortly before the completion of their studies. The Chief Secretary asked Mr. Wallis whether he could cite a single case, but received a reply in the negative. He was disinclined to excise the words, as this would have the effect of disturbing the confidence of the public in the medical profession. It was suggested that the term health officer should be altered to medical officer of health, to coincide with the term employed in the *Public Health Act*. The Chief Secretary promised to look into the matter.

On October 2 the Bill was recommitted on the third reading, in order that Clause 5 might be reconsidered. The Honourable J. Jelley moved that sub-clause (2), Clause 5, read: "The Board shall consist of five members who shall be appointed by the Governor." He claimed that in the Bill of 1908, this provision was contained after the medical profession had been consulted. He concluded the the medical profession had agreed to the proposal that the Governor should have the right to nominate all the members of the Board. In New Zealand the Registrar was appointed by the Government. The Registrar examined the certificates, diplomas and qualifications of the applicants for registration, and, if the qualifications were in order, there was nothing for the Registrar to do but to enrol the applicant. Thus the Registrar had less power than they proposed to give to the Board and yet they wanted to let the Board appoint itself. The Chief Secretary thought that the Board would be a well-constituted one under the Bill. He said that they had no right to anticipate that the Government would necessarily be opposed to the medical profession at any time. In reply to an interjection from Mr. Jelley, he stated that there had been some trouble in the past, but he did not think that the Medical Board had been responsible for it. The amendment was not passed. On the motion for the third reading, the Chief Secretary intimated that certain amendments that appeared to him to be needed to meet the wishes of the members, would be proposed by the responsible Minister in another place. The Bill was read for a third time.

The Bill was introduced into the Legislative Assembly on October 2, 1919, and read a first time. The motion for the second reading was introduced by the Honourable A. H. Peake, the Treasurer, on October 21, 1919. He dealt with the provisions very briefly and after Mr. T. Butterfield had foreshadowed some objections he would raise to certain of the clauses, the Bill was read and was considered in Committee. Mr. Butterfield then moved that in Clause 5, sub-section (2), the words "The Government may appoint two additional members" be inserted after "The Board shall consist of five members." He thought that the Government should have the controlling power. It was wrong for medical men to control their own profession. Mr. J. Gunn thought that a better method would be to give the Government the right to nominate three members and to give the medical profession and the Council of the University one representative each. The Treasurer accepted the proposal and the clause was amended accordingly.

The Treasurer moved an amendment to Clause 7 (see above) as follows:—

> To strike out all the words after "person" in the second line of the clause and insert "has been registered as a medical practitioner in South Australia for not less than five years."

The amendment was carried. After Clauses 8 to 17 had been passed, Mr. T. Butterfield called attention to sub-section (c) of Clause 19. It provided for a course of study of not less than five years' duration. A four years' course had previously been considered sufficient. He also moved the deletion of sub-section (2), in which the arrangements for reciprocity were embodied. The Treasurer held that the five years' course was needed to guarantee that people from other countries should have proper qualifications. Captain W. J. Denny, M.C., objected to the reciprocity clause. He did not think that any person in South Australia could say whether a foreign university gave rights and advantages equal to those that they registered under the measure. Many universities probably had never heard of the University of Adelaide. If a man satisfied the Board that he was in fact thoroughly qualified and that he was registered in the United Kingdom, or as far as other countries were concerned, had passed through a medical course of five years' duration, that should be sufficient. He objected to imposing a barrier in the way of an applicant from another country. The war was over and he claimed that if an eminent medical man desired to practise in the country, he should be allowed to do so. After the Treasurer had replied, the Committee divided and the amendment was negatived. The clause was passed in its original form.

Clauses 20 to 31 were passed. Clause 32 read as follows:—

> 32. (1) No person other than a person registered under this Act shall be competent to hold, or shall hold, any appointment as a medical officer (whether honorary or other):
>
> (a) in any public hospital, or
> (b) as a health officer, or
> (c) as a medical officer in any passenger or other vessel registered in the State and leaving any port therein.

The Treasurer moved that the words "as a medical officer" in the third line be struck out and that the words "as a medical officer" be inserted in (a) before the words "in any"; that the words "as a health officer" be struck out and that "as a medical officer of health" be inserted in lieu thereof. The amendment was carried.

Clause 34, which deals with the burial of a deceased person, did not apply when there was no registered medical practitioner or coroner within five miles of the place in which the person died. Mr. W. Harvey thought that five miles was too short a distance. He suggested that the clause be amended by making the distance twenty-five miles. The Treasurer promised to look into the matter. The clause was subsequently amended accordingly.

The remainder of the clauses were passed with but little discussion. A suggestion was made in connexion with Clause 35, which deals with unregistered persons who advertise or hold themselves out as medical practitioners. The clause was allowed to remain in its original form.

On November 4, 1919, the Legislative Council agreed to the amendments that had been introduced in the Legislative Assembly and the Bill was passed. It received assent on November 20, 1919.

The following is the text of the Act:—

An Act to Make Better Provision for the Registration of Medical Practitioners and to Regulate the Qualifications for and the Effect of Such Registration; and for Other Purposes.

Be it enacted by the Governor of the State of South Australia, with the advice and consent of the Parliament thereof, as follows:—

Part I.—Preliminary.

1. This Act may be cited as the *Medical Practitioners Act, 1919*.
2. The provisions of this Act are arranged as follows:—
   Part I.—Preliminary.
   Part II.—The Medical Board.
   Part III.—Registration and Qualifications therefor.
   Part IV.—Miscellaneous.
   Part V.—Regulations.
   Part VI.—Legal Proceedings.
3. In this Act—
   "Board" means the Medical Board of South Australia constituted by this Act.
   "Member" means member of the Board.

"Minister" means the Chief Secretary.
"President" means President of the Board.
"Public hospital" means a place declared by proclamation under Section 2 of the *Hospitals Act, 1867*, to be a public hospital.
"Register" means the Register of Medical Practitioners kept under this Act.
"Registered" means registered under this Act, and includes deemed to be so registered.
"Registrar" means the Registrar appointed under this Act.

4. The Acts mentioned in the Schedule are hereby repealed.

Part II.—The Medical Board.

5. (1) A Board, to be called "The Medical Board of South Australia," is hereby constituted, as from the day of the publication of the *Government Gazette*, pursuant to subsection (5) hereof, of the notice of the appointment of the original members thereof.

(2) The Board shall consist of five members, who shall be appointed by the Governor, after being respectively nominated as follows, namely:—
Three shall be nominated by the Minister:
One shall be nominated by the persons registered under this Act and for the time being resident in the State:
One shall be nominated by the Council of the University of Adelaide.

(3) When a vacancy occurs on the Board, whether by the expiration of a member's term of office or otherwise, the Governor shall, after nomination, appoint a member to fill the vacancy. If the member whose seat has become vacant was nominated by the Minister the person to fill the vacancy shall be nominated by the Minister, if by persons registered under this Act, he shall be nominated by the persons so registered, and if by the said Council he shall be nominated by the said Council.

(4) Any nomination to be made by the persons registered under this Act shall be made in manner prescribed.

(5) Notice of the appointment of any member shall be published in the *Government Gazette*, and, subject to Section 7, the notice so published shall be conclusive evidence that the member was duly nominated and appointed.

6. During the period from the passing of this Act until and including the day of the publication in the *Government Gazette*, pursuant to sub-section (5) of section 5, of the notice of the appointment of the original members of the Board, the South Australian Medical Board appointed under the Ordinance No. 17 of 1844, and in existence at the passing of this Act, shall discharge and may exercise all the functions, duties and powers of the Board hereby constituted; and from the day of such publication the said South Australian Medical Board shall cease to exist.

7. No person shall be eligible for appointment as a member unless at the time of nomination such person has been registered as a medical practitioner in South Australia for not less than five years.

8. (1) Each member shall be appointed for a term of two years: Provided that—

I. a member appointed to fill a vacancy caused otherwise than by a retirement of a member on the expiration of his term of office, shall be appointed only for the unexpired portion of the term of the member in whose place he is appointed; and
II. any retiring member shall hold office until his successor is appointed.

(2) Any person ceasing to be a member by reason of the expiration of his term of office shall be eligible for reappointment.

9. In addition to the retirement of members by the expiration of their terms of office, the seat of a member shall become vacant on—

(*a*) the death, lunacy, or insolvency of the member; or the execution by the member of a statutory deed of assignment for the benefit of his creditors; or his compounding with his creditors for less than twenty shillinges in the pound; or the conviction of the member of an indictable offence;
(*b*) the member's ceasing to be registered under this Act;
(*c*) the resignation of the member by notice in writing, posted or delivered to the President, or in the case of the President, to the Minister; or
(*d*) the absence of the member from three consecutive meetings of the Board without leave of the Board.

10. (1) If in any case the person or persons, or body, which has the right to nominate a person for appointment as a member, whether as an original or other member, fails to give notice in writing to the clerk of the Executive Council of the nomination within two months after being requested in writing by the said clerk to make such nomination, the Governor may appoint a member without nomination. In the case of the persons registered under this Act, the request to nominate shall be duly made by being published in the *Government Gazette*.

(2) A member appointed pursuant to this section shall be deemed to have been appointed after being nominated by the person or persons, or body, which had the right to nominate.

11. (1) The Governor may annually appoint a member nominated by a majority of the members, to be the President of the Board for the year: Provided that if, in any year, no member is so nominated before the first day of February in such year, the Governor may appoint the President for such year without nomination.

(2) The President, when present, shall preside at all meetings of the Board. In the absence of the President from any meeting, another member, chosen for the purpose by the majority of the members present and voting, shall preside.

(3) The person presiding, for the time being, shall have a casting vote as well as a deliberative vote.

12. Three members present at a meeting shall constitute a quorum of the Board.

13. (1) No act or proceeding of the Board shall be invalid or illegal in consequence only of the numbers of the members of the Board not being complete at the time of such act or proceeding.

(2) All acts and proceedings of the Board shall, notwithstanding the subsequent discovery of any defect in the appointment of any member thereof, or that any member was disqualified or disentitled to act, be as valid as if such member had been duly appointed and was qualified and entitled to act and had acted as a member of the Board, and as if the Board had been properly and fully constituted.

14. (1) The Board shall appoint a Registrar for the purposes of this Act: Provided that no person shall be appointed to or dismissed from the office of Registrar without the approval of the Minister first obtained.

(2) The Registrar shall act under the control of the Board.

15. No matter or thing done or suffered by the Board, or by any member or the Registrar, *bona fide* in the execution, or intended execution, of this Act, or the exercise or discharge, or intended exercise or discharge, of any of its or his powers or duties, shall subject the Board or any member, or the Registrar or any other person, or the Crown, to any liability in respect thereof.

16. (1) The Registrar shall every year, in the month of July, prepare a balance-sheet, showing the income and expenditure of the Board for the period of twelve months ended on the thirtieth day of the preceding month of June, and shall transmit the same to the Minister.

(2) The accounts of the Board shall, once at least in every year, be audited by the Commissioner of Audit, who shall, in respect of such accounts, have all the powers which may be exercised by him under the *Audit Act, 1882*, and any Act for the time being in force relating to the audit of public accounts. The report of such Commissioner on any such audit shall be transmitted to the Minister.

Part III.—Registration and Qualifications Therefor.

17. (1) The Registrar shall keep a Register to be called "The Register of Medical Practitioners."

(2) A person shall be registered by the entering in the Register of his name, and such other particulars relating to him as are prescribed.

18. All persons who, immediately before the passing of this Act, were registered under the Acts hereby repealed, shall be registered under this Act, and, subject to section 26, shall be deemed to be so registered as from the passing of this Act.

19. (1) In addition to the persons mentioned in section 18, every person shall be entitled to be registered who proves to the satisfaction of the Board that he—

(*a*) is the holder of a degree in medicine or surgery of any university in the Commonwealth of Australia or the Dominion of New Zealand which is legally authorized to grant such degree; or

(*b*) is registered, or possesses a qualification entitling him to be registered, under the Medical Acts of the Parliament of the United Kingdom, or any Act amending or substituted for those Acts, or any of them; or

(*c*) has passed through a regular graded course of medical study in a school of medicine in some part of the British Empire or some other country, such course being not less than five years' duration, and being recognized by the Board as not lower in standard than that required in the State, and—

I. has received, after due examination, from a university, college, or other body, duly recognized for the purpose in such part or country, a degree or diploma, certifying to his ability to practise medicine or surgery, and

II. is by law entitled to be registered, or to practise, as a medical practitioner in such part or country.

(2) Notwithstanding anything in this Act, the Board, in considering an application to be registered, shall not be required to recognize any degree, diploma, or other qualification granted in any country, not being part of the British Empire, unless in such country a person registered under this Act is granted rights and advantages equal to those granted in such country to the holders of such degree, diploma, or qualification.

20. (1) Any person desiring to be registered shall submit to the Board proof of the qualification upon which he relies.

(2) The Board shall require the attendance before it of the person applying to be registered, unless he is specially excused by the Board, and may require the attendance of any other persons.

(3) The Board may examine any person upon oath, affirmation, or declaration, and for such purpose any member may administer an oath, affirmation, or declaration.

(4) A summons issued by the Board requiring the attendance of any person or the production of any documents, and signed by the Registrar, shall have the same effect as a subpœna *ad testificandum* or *duces tecum*, as the case may be, issued out of the Supreme Court in a civil action; and obedience thereto, or non-observance thereof, or refusal to give evidence, shall be enforced or punished by a Judge of the Supreme Court in chambers, in the same manner as in the case of disobedience or non-observance of a subpœna issued out of the said Court, or refusal to give evidence before the said Court.

(5) If not satisfied that the applicant is entitled to be registered the Board may refuse the application or adjourn the same for further consideration.

21. (1) If any person who applies for registration is dissatisfied with the decision of the Board, it shall be lawful for him, by motion to the Supreme Court, within three months of the giving of such decision, to apply to such Court for an order directing the Board to register him.

(2) The Court, or a Judge thereof, may order that the person applying be registered, or that he be registered conditionally or upon terms, or may decline to make such or any order.

22. (1) No person shall be registered until he has paid to the Registrar a registration fee of one guinea: Provided that any person entitled to be registered pursuant to section 18 shall be registered without payment of a fee.

(2) Notwithstanding his registration, or anything in this Act, no person, unless registered pursuant to section 18, shall, after the year nineteen hundred and twenty, be deemed, at any time in any year, to be registered, until he has paid a renewal fee of one guinea for such year, unless on registration or afterwards he has paid a fee of five guineas. If paid on registration, such fee of five guineas shall be a commutation of the registration fee and all renewal fees; if paid after registration it shall be a commutation of all renewal fees.

23. (1) When any person has paid the registration fee and become registered, the Registrar shall deliver to him a certificate of registration in the prescribed form.

(2) On application made to him at any time and on payment of the prescribed fee, the Registrar shall issue to any registered person a duplicate certificate of his registration.

24. (1) When a person has applied to be registered, the President, or, in his absence from the City of Adelaide, any other member of the Board, upon being satisfied that such person is entitled to be registered, and upon payment of the registration fee required by section 22, may grant to such person a provisional certificate of registration in the prescribed form.

(2) When a person has obtained a provisional certificate he shall be deemed to be registered under this Act until—

(*a*) the date stated in such certificate, or

(*b*) such later date as is fixed by the Board,

which in no case shall be later than three months from the granting of such certificate: Provided that if the Board, before the date so stated or fixed, have reason to believe that such person is not entitled to be registered, they may, without prejudice to his application to be registered, cancel his provisional certificate; and such person shall thereupon cease to be deemed to be registered.

(3) If a person to whom a provisional certificate has been granted becomes registered, his registration shall, unless otherwise decided by the Board, date from the granting of his provisional certificate.

25. Every registered person who obtains any degree or qualification other than that in respect of which he is registered, shall be entitled, on payment of the prescribed fee, to have such other degree or qualification inserted in the Register, in substitution for or in addition to the qualification therein stated.

26. The name of any person—

(*a*) whose registration has been obtained by fraud or misrepresentation; or

(*b*) whose qualification has been withdrawn or cancelled by the university, college, or other body by which it was conferred, or by the General Council of Medical Education and Registration of the United Kingdom; or

(*c*) who either before or after his registration, has been convicted of any felony or misdemeanor, or of any offence which, if committed in the State, would be a felony or misdemeanor; or

(*d*) who is deemed by the Board to have been guilty of infamous conduct in any professional respect—

may be removed from the Register by order of the Supreme Court or a Judge thereof, on application by motion made in that behalf by the Board or the Registrar, and such person shall upon the removal of his name cease to be registered: Provided that the name so removed may be restored by order of the Supreme Court and thereupon such person shall again be a registered person.

27. (1) The Registrar shall from time to time strike out in the Register the names of all registered persons who have died, and shall make such alterations and amendments in the Register as the Board from time to time directs, for the purpose of making the same an accurate record of the names, addresses and qualifications of all persons for the time being registered.

(2) To assist the Registrar in the discharge of his duties under this section, the Registrar-General of Births and Deaths, on receiving notice of the death of any person registered under this Act, shall forthwith inform the Registrar in writing of such death.

28. The Register shall be kept in the office of the Registrar, and shall at all times be open to inspection by any person on payment of the prescribed fee.

29. (1) A copy of the Register shall, in the month of January in each year, be sent by the Board to the Minister, and shall by him be published in the *Government Gazette*.

(2) Any copy of the Register appearing in the *Government Gazette* shall in all Courts and before all persons be *primâ facie* evidence that the persons therein specified, and no others, are registered: Provided that a certificate purporting to be signed by the Registrar, and stating that, at the date mentioned therein, a person was or was not

registered shall be *primâ facie* evidence of the truth of such statement.

Part IV.—Miscellaneous.

30. Wherever in any other Act now or hereafter in force, or in any other instrument, the expression "legally qualified medical practitioner" or "duly qualified medical practitioner" is used, such expression shall, from the passing of this Act, unless a contrary intention clearly appears, be deemed to mean a person registered under this Act.

31. Every person registered under this Act shall be entitled to sue in any Court of competent jurisdiction for the recovery of his fees or other remuneration for professional services of any kind; and no person other than a person so registered, or a person who had practised as a surgeon, physician, or medical practitioner in the State for a period of five years at least before the sixth day of December, eighteen hundred and eighty-nine, shall be entitled to sue or counter-claim for or to set-off or otherwise recover any charge or remuneration for any medical or surgical advice, attendance, service, or operation.

32. (1) No person other than a person registered under this Act shall be competent to hold, or shall hold, any appointment—

(a) as a medical officer in any public hospital, or
(b) as a medical officer of health, or
(c) as a medical officer in any passenger or other vessel registered in the State and leaving any port therein.

Any person who holds, or purports to hold, any such appointment, contrary to this section, shall for such offence be liable to a penalty not exceeding twenty pounds.

(2) Subject as provided by section 33, no certificate by a medical practitioner, required by any Act, shall, if signed in the State, be valid unless the person signing the same was, at the time of so signing, registered under this Act, or had practised as a surgeon, physician, or medical practitioner in the State for a period of five years at least before the sixth day of December, eighteen hundred and eighty-nine.

33. No person shall sign any certificate of cause of death required by section 20 of the *Registration of Births and Deaths Act, 187¼* (as enacted by section 5 of the *Births, Marriages and Deaths Registration Amendment Act, 1907*), unless he—

(a) is a person registered under this Act, or
(b) had practised as a surgeon, physician, or medical practitioner in the State for a period of five years at least before the sixth day of December, eighteen hundred and eighty-nine: Provided that this section shall not apply where there is no person so registered, and no person who had practised as aforesaid, residing within a distance of five miles of the place where the death occurred.

34. No burial of a deceased person shall take place until—

(a) a person registered under this Act, or a person who had practised as a surgeon, physician, or medical practitioner in the State for a period of five years at least before the sixth day of December, eighteen hundred and eighty-nine, has signed and given a certificate of the cause of death of such deceased person, or
(b) a coroner of the State, within the meaning of the *Coroners Act, 188¼*, has made and signed an order for the burial:

Provided that this section shall not apply where there is no person so registered, and no such coroner, residing within a distance of twenty-five miles of the place where such deceased person died.

35. (1) No person, not being registered under this Act, shall either directly or indirectly, by any name, word, or letter, or by any title or designation, whether expressed in words or by letters, or partly in one and partly in the other, or by any sign, device, article, or other thing whatsoever, or by any other means whatsoever, whether—

(a) by having the same attached to or exhibited on, in, at, or near, his place of business or residence, or any other place whatsoever, or
(b) in any letter, newspaper, magazine, book, programme, circular, handbill, placard, card, letter paper, billhead, receipt form, or invoice, or any document or paper used in connection with any business, practice, or profession, or
(c) in any other way whatsoever,—

advertise or hold himself out as being, or pretend to be a doctor of medicine, licentiate in medicine or surgery, master in surgery, bachelor of medicine or surgery, doctor, legally or duly qualified or registered medical practitioner, accoucheur, or other medical or surgical practitioner, or the holder of any other degree, diploma, licence, or certificate in medicine or surgery.

(2) Every person who, for himself or as assistant, servant, agent, or manager, does or permits any act, matter, or thing in any way contrary to this section, shall be liable for each and every such offence to a penalty of not less than five pounds and not more than fifty pounds, or to a term of imprisonment not exceeding six months, with or without hard labour: Provided that any person who had practised medicine or surgery continuously in the State for a term of not less than five years previous to the sixth day of December, eighteen hundred and eighty-nine, shall not be liable to any penalty under this section by reason only of his using, or continuing to use, the title of "doctor."

36. Every person who exhibits or publishes, or causes, permits, or suffers to be exhibited or published, any letter, or any circular, handbill, placard, card, letter-paper, billhead, receipt form, or invoice, or any document or paper to be used in connection with any business, practice, or profession, or other advertisement of any kind, whereby any person advertises or holds himself out contrary to any provision of section 35, or attempts so to do, shall be liable for every such offence to a penalty of not less than one pound and not exceeding fifty pounds: Provided that this section shall not apply to any newspaper or magazine proprietor or printer publishing such advertisement before written notice to him from the Registrar that such advertisement is contrary to the said section.

37. Any person who—

I. makes or causes to be made any falsification in the Register or in any matter relating to the Register; or
II. knowingly makes any false statement upon any examination before the Board, or in any document to be used in evidence before, or to be submitted to, the Board; or
III. utters or puts off, or attempts to utter or put off, as true before the Board any false, forged, or counterfeit degree, diploma, licence, certificate, or other document or writing; or
IV. procures or attempts to procure himself or any other person to be registered by making or producing, or causing to be made or produced, any false or fraudulent statement, declaration, or representation, either verbal or in writing; or
V. personates or represents himself as being the person referred to in any degree, diploma, licence, certificate, document, or writing presented to the Board, or in any certificate granted under this Act or under the Acts hereby repealed;

or who—

I. fraudently or by false representation obtains any certificate of registration under this Act; or
II. forges, alters, or counterfeits any such certificate or any certificate under the Acts hereby repealed; or
III. utters or uses or attempts to utter or use any such forged certificate, knowing the same to have been forged; or
IV. falsely advertises or publishes himself as having obtained any such certificate, or as being registered under this Act, or permits any such advertisement or publication,

shall be guilty of a misdemeanor, and be liable to imprisonment, with or without hard labour, for any term not exceeding three years.

38. All moneys received by the Board under this Act, shall be paid to the Treasurer for the public uses of the State.

Part V.—Regulations.

39. The Governor may, on the recommendation of the Board, make regulations prescribing all matters which by this

Act are contemplated, or permitted to be so prescribed, or which may be necessary or convenient to be prescribed for giving effect to this Act, including regulations for the following, among other purposes:—

I. Prescribing the manner in which nominations of members of the Board are to be made by the persons registered under this Act:
II. Regulating the meetings and proceedings and the conduct of the business of the Board:
III. Prescribing the duties of the Registrar:
IV. Regulating the manner of keeping and the form of the Register:
V. Prescribing forms to be used and fees to be paid, either in addition to or in substitution for any forms and fees prescribed by this Act.

Part VI.—Legal Proceedings.

40. The Supreme Court, or a Judge thereof, making or declining to make an order in any matter under this Act, may make any order and give any directions as to the costs thereof which it or he thinks proper.

41. All proceedings in respect of offences against this Act, not being indictable offences, shall be disposed of summarily.

42. There shall be an appeal in respect of proceedings in respect of offences against this Act.

43. In the event of an appeal in respect of proceedings in respect of offences against this Act, a special case may be stated.

Medical Societies.

MELBOURNE PÆDIATRIC SOCIETY.

A meeting of the Melbourne Pædiatric Society was held at the Children's Hospital, Carlton, on December 10, 1919. In the absence of the President, Dr. Stewart Ferguson, Dr. W. Kent Hughes conducted the meeting.

Dr. M. D. Silberberg brought forward a girl, *æt.* 13, whom he considered the subject of fibrosis of the lung and enlarged bronchial glands. The girl had been troubled with a persistent cough, loose in character and associated with a moderate amount of non-offensive sputum, which dated back to an attack of pertussis six years before. The child was one of a family of five; the four others were all healthy. The mother, now dead, was said to have had a "weak chest." On examination the child seemed well developed. Crepitations and râles were to be heard at both bases. On the right side d'Espine's sign, *i.e.*, increased pectoriloquy in the interscapular region, was present and the Eustace Smith bruit was audible. The latter sign consisted in a venous hum over the jugular vein, best heard with the neck in extension. According to the radiographer's report in 1915 the hilus shadows on each side were somewhat exaggerated. The posterior mediastinum was not quite clear in its middle part and some enlargement of the glands probably existed, but it was not very definite. A later skiagram, taken in 1919, was reported upon as follows: "Marked hilus fibrosis spreading out to each base, with dense mediastinum, the condition most probably tuberculous." Repeated examinations had not disclosed any tubercle bacilli in the sputum and the von Pirquet test was negative. The response to the Wassermann test was returned as "feeble partial." The patient had not improved on expectorants, *ol. morrhuæ* or vaccines. He intended to adopt anti-specific treatment, but would like some expressions of opinion from his colleagues with regard to both diagnosis and treatment.

Dr. H. Douglas Stephens enquired of Dr. Silberberg what he regarded as the essentials in signs and symptoms when arriving at a diagnosis of enlarged bronchial glands and what relative values Dr. Silberberg would assign to interscapular dulness, d'Espine's sign and skiagraphic appearances. He (Dr. Stephens) always made the diagnosis of enlarged bronchial glands with considerable misgiving, unless he could obtain good radiographic evidence. A hoarse, persistent cough was very suggestive, but he had found that enlargement of the bronchial glands, unless gross, was a condition very difficult to diagnose confidently from the evidence afforded by signs and symptoms alone. Undoubtedly, in a great many cases, the diagnosis was determined by the skiagrams. He was not disposed to place any value on Eustace Smith's sign, which could be elicited in nearly all marasmic children and, in fact, in all children under the age of seven. Lombardi's sign, which consisted in the presence of dilated venules between the scapulæ, was sometimes useful. Recognition of the condition under discussion was of very great importance, for tuberculous enlargement of the bronchial glands was of very much more frequent occurrence in children than primary tuberculosis of the lung. In conclusion he would repeat that a well interpreted skiagram was the most important single factor in diagnosis.

Dr. S. O. Cowen said that the condition they were considering was not at all uncommon and was a frequent cause of chronic cough in children. He would confine his remarks to the pathology and physical signs. Pathologically, these cases fell into two groups; those in which the glands enlarged primarily, with consequent obstruction to lymphatic drainage, and those in which continued absorption of toxic products led to secondary enlargement of the glands. In either case the results were enlargement of the glands and peri-bronchial and peri-vascular fibrosis, since the lymphatics were mainly centred round the vessels and bronchi. Tuberculosis and syphilis were common ætiological factors. He was becoming more and more convinced of the importance of chronic pyogenic processes in different parts of the air passages as a cause of the condition.

The important physical signs were: increase in the normal, right, interscapular dulness, downward and to the right; diminished breath sound, with prolongation of expiration over the right lower lobe and increased vocal fremitus over the same area. Occurring together, these signs were strongly suggestive, but always required confirmation by careful X-ray examination. d'Espine's sign was of some value, but no reliance could be placed on that of Eustace Smith. The predominance of signs and often of organic changes on the right side, was worthy of note.

Dr. W. Kent Hughes asked whether the nose and accessory sinuses had been examined. His experience was that the vast majority of bronchiectatic patients had sinus trouble and that attention to the sinuses frequently led to a decided improvement in the bronchiectasis. He would very much like to see a bronchoscopic examination carried out in the girl Dr. Silberberg had presented for discussion.

Dr. Silberberg, in reply, said that his chief purpose in showing the patient was that members might have an opportunity of comparing the X-ray photographs with the physical signs. He had always found enlargement of the bronchial glands a difficult condition to diagnose. When examining from this point of view, he always looked for d'Espine's sign, which, however, he regarded as positive only when the pectoriloquy extended down to the interscapular region. He always secured an X-ray examination and frequently got reports of hilus shadows, with or without fibrosis of the lung. The glands would not show in an X-ray photograph unless they were very large or calcified.

In reply to Dr. Kent Hughes, he mentioned that the child was deaf when she first came to the hospital and adenoids had been removed. He would have the condition of the antra investigated and would very much like a bronchoscopy. The partial Wassermann reaction he was disposed to regard as of some significance in children.

Dr. Rupert Downes presented for discussion a baby, aged 18 months, who was originally brought to the Hospital on account of a large vascular tumour in the axilla and a diffuse capillary angioma of the hand of the same side. The axillary tumour had been present for 6 months, at the end of which period it had attained the size of a cricket ball. It was dark blue, felt like a "bag of worms' 'and was obviously an angioma. With the nævoid condition of the hand was associated fusiform swelling of the fingers, constriction of the wrist and a general enlargement of the whole hand. The growth in the axilla had been treated in the first place by electrolysis, applications of 15 milliampères, for 10 minute periods, at fortnightly intervals, being carried out on six occasions. As a result the tumour became very hard, so that he was led to undertake its operative removal. At operation he found the walls of the vascular spaces firm and calcified; there was no free blood and no clamping of vessels was necessary. He was of opinion that but for the cicatri-

zation induced by the preliminary electrolysis, operative measures in this case would have been extremely hazardous, as the apex of the tumour impinged on the axillary artery and dissection was necessary to free the mass from this vessel. A point to which he wished to draw attention was that following the above measures, improvement was noted in the condition of the hand; the colour definitely faded and the hand generally diminished in size. He might mention that nine applications of radium to the hand had been made prior to the child's first attendance at the Hospital. He was inclined to regard the improvement in the hand following treatment directed to the axillary tumour as coincident.

In reply to a question Dr. Downes stated that the removal of the tumour in the axilla was undertaken two weeks after the last electrolysis. With reference to the hand, Dr. Downes thought that carbon dioxide snow would probably accomplish a great deal in the direction of improving the nævoid condition, but he did not think this would be a very great benefit as long as the hyperplasia persisted.

Dr. Roland Wettenhall considered the result obtained in the treatment of the angioma of the axilla excellent. Undoubtedly the operation so successfully undertaken would have been difficult, if not impossible, had the way not been paved by the electrolysis. Regarding the hand, he agreed with Dr. Downes, that whereas snow would probably benefit the angioma, it could scarcely be expected to influence the co-existent hyperplasia; surgery was also out of the question. There remained X-rays and radium, of which the latter had already had some trial in this case. The action of X-rays in sufficient doses was to induce atrophy in the most cellular tissues and he would suggest the prolonged application of well filtered rays, of high penetration, in order to obtain atrophy of the deeper tissues.

Dr. H. Douglas Stephens quoted a case in which a nævus of the knee was associated with a nævoid and hyperplastic condition of the hand, very similar to that in the case Dr. Downes had demonstrated. That case occurred eight years ago. He had applied electrolysis successfully to the nævus on the knee, but did nothing to the hand. He had recently seen this child; the former nævus on the palm of the hand had practically disappeared. The only explanation he could offer was that the constant pressure occasioned the nævus by the use of the hand, had in time led to atrophic changes in the growth. If some form of constant pressure were devised, it might be of benefit in the case under discussion, *e.g.*, a rubber glove, fitted to the hand when cold and relatively small.

Dr. Downes' second case was that of a girl, *æt.* 13, affected with an extensive granulomatous condition of the nose and palate. The lesions had existed for over twelve months and the nose was now swollen and inflamed, leading to occlusion of the nares. Sticky, purulent exudate escaped from the lesions of the nares and the septum was observed to be very swollen. The intra-oral granulations extended well over the hard palate and involved the upper alveolar process. Both the child's parents had died of tuberculosis. She had two brothers, one of whom was said to suffer from "knee trouble."

The Wassermann reaction had twice been returned as negative. He had sent some granulation tissue to the laboratory and Dr. Webster had reported on histological grounds, that the process was tuberculous. He understood that an animal inoculation test had also been instituted with an emulsion of the tissue. Treatment with tuberculin (B.E.), had been commenced, but it was as yet rather early to look for results.

Dr. Wettenhall said that his first impression on looking at the child was that the condition was probably syphilis or lupus, but on closer examination he could not say that it fitted his idea of either of these processes. With reference to the nose he drew attention to the sticky exudate in various patches, with no ulceration; the affected portion of the nose was firm, of a brownish dirty colour and the deformity and blocking the nostrils were apparent. The duration of the process seemed to him to argue against syphilis; in lupus there was generally some indolent ulceration. He had been impressed with the close resemblance of the condition to the descriptions given of rhinoscleroma—a very rare disease—which, to his knowledge, had not been met in Australia. The leading feature about rhinoscleroma was, as its name implied, extreme hardness, and in this particular the lesions in the case under discussion scarcely merited the term. In other points, *e.g.*, situation, outlying nodules, gummy exudate, the granuloma was consistent with rhinoscleroma. Asked whether sporotrichosis might be considered in the diagnosis, Dr. Wettenhall replied that the condition named was a much more active process than that they were considering; the course of rhinoscleroma was one of very chronic progression, death eventually ensuing upon involvement of the larynx.

Dr. W. Kent Hughes remarked that, though he had never seen an instance of rhinoscleroma, he well remembered a case of lupus at St. Bartholomew's Hospital, which much resembled the condition in the child presented by Dr. Downes. In the instance to which he referred the process affected the tongue and spread to the lower jaw, resulting in an extensive granuloma of the mucous membrane of the mouth. That case had been cured with Spengler's "I.K." therapy and was the second case to impress him with the value of Spengler's treatment in tuberculosis.

Dr. Reginald Webster remarked that in forming his opinion that the section was tuberculous in nature, he had not at first taken into account the possibility of rhinoscleroma. A definite histology was described for the latter condition and he had been unable to reconcile the histological appearances in this case with the picture he conceived to be that of rhinoscleroma after consulting the text-books on the subject. On the other hand, he thought the microscopical evidence of tuberculosis was definite, general lymphocytic permeation with here and there giant cells and microscopical areas of caseation. A bacillus closely resembling the pneumo-bacillus (Friedländer) was described for rhinoscleroma, but, if he remembered correctly, conclusive evidence of its causal relationship to rhinoscleroma was lacking. In the case they were discussing he had isolated a Gram-negative bacillus, resembling the *B. friedländer.* in being an active fermenter of various sugars, but he was not prepared to say that it was the infective agent in the case Dr. Downes had brought before them. In conclusion, Dr. Webster stated that he had examined the guinea-pig that day, but could find no trace of a nodule at the point of inoculation (subcutaneous); in other respects the animal seemed perfectly well and four weeks had elapsed since it was inoculated.

Dr. H. Hume Turnbull requested the consideration of the meeting for the case of a girl, *æt.* 8, who had not been well since May, 1919. She had suffered several hæmoptyses, had lost a considerable amount of weight and was now the subject of a severe cough. There was abundant sputum, purulent and tinged with blood. The breath was very offensive. As far as could be gathered the girl came of a healthy family; she had always lived in the country and careful inquiry had failed to elicit any facts which might support a diagnosis of hydatid disease. The report of the radiographer was to the effect that marked fibrosis of the base of the right lung existed, with a cavity beneath the outer half of the right clavicle and consolidation at the right apex. Clubbing of the fingers was pronounced. The physical signs observed on examination of the chest were as follow: The right apex did not expand as well as the left; there was a "cracked-pot" note at the right apex posteriorly; dulness was present over the remainder of the lung. Cavernous breathing was heard at the right apex anteriorly and posteriorly. There were some râles associated with bronchial breathing and a few crepitations over the lower lobe posteriorly. On the left side of the chest, at the level of the angle of the scapula, a dull percussion note was obtained and bronchial breathing was heard over an area of the size of a five-shilling piece. The result of the Wassermann reaction was "feeble partial."

Dr. Turnbull considered that the diagnosis lay between empyæma as ordinarily understood, interlobar empyæma and a syphilitic affection of the lung. In respect to the two first mentioned it would appear that rupture had occurred and communication with a bronchus had been established. He mentioned syphilis of the lung, because, in the only definite instance of such a condition he had encountered, the patient had similar physical signs as the child he was now presenting. The question of needling the chest arose. He was not anxious to do so, especially as the skiagrams were not suggestive of a localized collection of pus. He invited

suggestions as to diagnosis and treatment; posture had been tried, but was of little use.

Dr. H. Douglas Stephens considered that the great difficulty in the way of successful treatment was due to the fact that it was not possible to remove the fibrosis of the lung which led to dilatation of the bronchi. He had met similar conditions not infrequently, sequent on pneumonia and pleurisy; he regarded them as examples of pleurogenous fibrosis. In regard to needling. from the X-ray photograph and his own examination he thought that fluid would most likely be obtained at a point just mesial to the angle of the right scapula.

Dr. M. D. Silberberg asked whether any benefit resulted from vaccines and suggested that the child was old enough to wear a Burney Yeo's inhaler, by means of which appropriate inhalation might be given a good trial. He would be inclined also to institute anti-syphilitic measures.

Dr. Turnbull, in reply, said that, as yet, vaccine treatment had not been tried in this case. He intended to adopt some scheme of continuous inhalation and thought that eventually consideration might have to be given to the question of inducing artificial pneumothorax.

Dr. Turnbull next showed a boy, aged 12, the most obvious feature about whom was extreme cyanosis. Although never able to do very much on account of shortness of breath, the boy had been in moderately good health until three days before his admission to Hospital, when he was seized with hæmoptysis. Since then coughing of dark blood had been frequent. An extreme degree of clubbing of the fingers and toes was present. Dr. Turnbull exhibited a skiagram. Dr. Hewlett's report was that the aortic shadow was broad and the right auricle enlarged; otherwise, nothing abnormal was detected.

Dr. Turnbull remarked that there were two points about this case of congenital heart disease. The heart was only very slightly enlarged. There was no murmur. The boy's red corpuscles numbered 5¼ millions. There was no pulse at the left wrist. He was at a loss to explain the absence of the left radial pulse, except upon the ground of congenital abnormality. In connexion with this case he would ask Dr. Webster to show a specimen, secured at a recent post-mortem examination, which would seem to represent the most probable condition of affairs in the case of the boy before them. In the post-mortem specimen to which he had referred there was so extreme a degree of patency of the *foramen ovale* as to amount to a virtual absence of the interauricular septum.

In reply to a question by Dr. Stephens. Dr. Turnbull said that he considered the prognosis entirely bad; there was already great diminution of reserve power and hæmoptyses were frequent.

Dr. W. Kent Hughes showed a case of antral disease in a girl, *æt.* 7. The child had been troubled greatly with insomnia and headache, in addition to which she made constant complaint of "something dropping in the back of her throat." Frequent feverish attacks interrupted the child's progress and contributed to her rather poor state of nutrition. An X-ray photograph had disclosed an increased density in the left antrum. Dr. Kent Hughes had performed a left radical antrum operation, using the gingivo-labial incision to gain access to the anterior wall of the antrum. The cavity was opened and curetted, the mucous membrane being found in an hypertrophic condition and the site of numerous polypoid growths. The operation was completed by making an opening into the inferior meatus.

Dr. Hughes said that his object in showing this patient was to impress upon the members the frequency of antral disease in children; in his opinion, all patients with constant naso-pharyngeal discharge and all those with asthma should be examined from the point of view of possible antral trouble. No doubt the infectious fevers left their aftermath of sinusitis in many instances.

The maxillary antrum was, practically, a closed cavity, badly drained, and infections of the nasal mucous membrane were very prone to involve that of the antrum. If polypi were found in the nose, it was extremely probable that they were also present in the antrum. Dr. Kent Hughes indicated the possible importance of infections of the accessory sinuses in rheumatism and rheumatoid conditions, although he did not think they could be given a significance equal to that of the tonsils in this respect. Irrigation was often sufficient for recent, acute cases, but in chronic affections of the sinuses radical operation was the only measure of any use.

Dr. H. Hume Turnbull remarked that, in the case of a child with a chronic cough and blood-stained sputum, he was always on the look-out for antral disease. It was quite probable that the frequency of antral disease in children, emphasized by Dr. Kent Hughes, accounted for many of the failures attendant on operations for enlarged tonsils and adenoids.

Dr. Kent Hughes laid great stress on the necessity for early recognition of sinusitis. There was little or nothing known about the production of polypoid mucous membrane. As it was common in children, it might account for many chronic and resistant adult cases of sinus trouble and asthma.

Dr. Kent Hughes next exhibited an instance of a surgical accident which occurred as a rare complication of operations upon the accessory sinuses. The patient was a boy, in whom he had had occasion to carry out a double operation for antral disease; on one side he had removed portion of the ethmoid. After the operation the boy was observed to have complete oculo-motor palsy and he complained that he could not see. The discs were examined one week after the operation and appeared to be normal, although the boy said he could not see. Several weeks later an examination of the *fundus oculi* showed evidence of optic atrophy. Some improvement had followed in the oculo-motor paralysis, but the vision at present did not amount to any more than perception of light.

Dr. Hughes said that he remembered only one other similar case, which occurred twenty years ago. The condition was described by Onodi and its explanation was very obscure.

Dr. F. Kingsley Norris gave the details of the treatment he had pursued in the case of a boy, *æt.* 9½, who had exhibited enuresis ever since he was a baby. The urine was very acid, but otherwise was clear; the prepuce was long and free, but there were no signs of irritation. The nose and throat had been examined and pronounced clear. As a first measure the urine was rendered alkaline, but no improvement in the enuresis followed. Belladonna was then pushed to the limit of the boy's tolerance and he went on wetting the bed regularly. Circumcision was followed by no benefit.

The first line of treatment to yield any encouragement was pituitrin; the boy was given 0.5 c.cm. doses and after several days succeeded in keeping dry for four nights. However, this was a temporary improvement only and increased doses of pituitrin did not affect the relapse.

The boy was then subjected to lumbar puncture and the withdrawal of 10 c.cm. of cerebro-spinal fluid was followed by the intrathecal injection of 12 c.cm. normal saline solution. He came to the Hospital two days later, looking very ill, vomiting, sweating and showing a definite Kernig's sign. The boy also complained of severe headache. He was sent indoors and rapidly improved. During the week that he was in hospital he did not wet the bed once; he did so for two nights after going home, but for the last 30 days there had been no enuresis.

Dr. Norris mentioned another patient, under the care of Dr. Jeffreys Wood, who had received similar treatment; she was known to have been free of enuresis for 6 weeks after leaving hospital, but after that they had lost trace of the child. There was not, to his knowledge, any adequate explanation of the rationale of the treatment. The meningeal manifestations in the patient he had shown were sufficiently alarming to make him hesitate to follow the same line again.

The meeting terminated with the exhibition of pathological specimens by Dr. Reginald Webster.

The undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:—

Roy Buckingham Trindall, Esq., M.B., Ch.M., 1915 (Univ. Sydney), 314 Marrickville Road, Marrickville.

Hugh Hunter, Esq., M.B., 1918 (Univ. Sydney), c/o. Dr. J. G. Hunter, Mascot.

We regret to announce that Dr. John Michael McDonagh, of Sydney, died on January 29, 1920, at the age of 61 years.

THE MELBOURNE HOSPITAL APPOINTMENTS.

A great deal of discontent and warm feeling has been exhibited both in the lay press and in various circles in Melbourne concerning the appointment of two medical practitioners to the positions of Honorary Physicians to the Out-Patient Department at the Melbourne Hospital. It appears that the vacancies were advertised in the lay press early in January, 1920. The Committee of Management of the Hospital ignored the fact that *The Medical Journal of Australia* is the proper channel for approaching the members of the medical profession in connexion with professional appointments. The applications closed on January 14, 1920. There were nine candidates. Of these, six had served in the Australian Imperial Force, as follows:—

Paul Grieg Dane, M.B., 1905, Ch.B., 1906, M.D., 1909, Melb.

Frederick Donald Herbert Blois Lawton, M.B. *et* Ch.B., 1913, Melb.

Montefiore David Silberberg, M.B., 1906, Ch.B., 1907, M.D., 1909, Melb.

James Alexander Smeal, M.B. et Ch.B., 1913, Melb.

Walter Ernest Summons, M.B., 1903, Ch.B., 1904, M.D., 1907, Melb.

Roy Fallowes Watson, M.B. *et* Ch.B., 1913, Melb.

The seventh candidate was Sydney Pern, M.R.C.S., Eng., L.R.C.P., Lond., 1900, who had a South African war record to his credit.

William John Denehy, M.B. *et* Ch.B., 1911, Melb., had volunteered for active service, but had been rejected as unfit.

Ralph Parker McMeekin, M.B. *et* Ch.B., 1914, Melb., the last candidate, had no war record.

It may be presumed that each of these candidates submitted to the Advisory Board a record of his professional attainments and experience. The Advisory Board has the function of examining the applications and reporting to the Hospital Committee. The Board met on January 14 and recommended the appointment of Drs. McMeekin and Lawton.

It is claimed that the Advisory Board exceeded its powers in making a definite recommendation. In any case, the records of all the candidates should have been submitted for the consideration of the full Committee.

As soon as it became known that the Advisory Board had recommended the appointment of a medical practitioner who had not been on active service, the Returned Medical Officers' Association, the Returned Sailors and Soldiers' Association and the Returned Sailors' and Soldiers' Fathers' Association requested the Committee of Management of the Melbourne Hospital to receive a deputation for the purpose of calling attention to the necessity of appointing returned medical officers to vacant positions on the Hospital staff, provided that men with suitable attainments were included among the applicants. The Committee considered this application on January 27, 1920. Dr. T. P. McInerney suggested that the deputation should be admitted, but that there should be no argument on the question. Dr. W. Moore put forward the extraordinary argument that no outside body should be allowed to interfere with the management of the Hospital. We would point out that the Melbourne Hospital is a public institution and that the medical profession, at least, has an absolute right to interefere in the event of any apparent injustice being done, either to the patients in the Hospital or to any of its members. The deputation was heard.

The members of the deputation pointed out that there could be no question concerning the ability of many of the returned medical officers who had applied, to fill the positions in a satisfactory manner. The principle that preference should be given to returned medical men, other things being equal, was therefore urged upon the Committee and it was claimed that there was no justification in this particular instance to appoint anyone other than a returned man. The Committee determined by nine votes to six to appoint the nominees of the Advisory Board.

It is difficult to understand the attitude of either the Advisory Board or the Committee of Management. We hold no brief for any of the candidates, but claim that justice demands the following procedure. The professional records of each of the candidates should be examined closely in the first instance. From these records it should be possible to arrange the candidates in order of professional suitability. In the next place the selection should be made after due regard has been given to the question of war service. Preference should be given in the first place to men who have served abroad in the Australian Army Medical Corps, and in the second place to those who have volunteered but have been rejected. The Board of Management will be well advised if they reconsider the appointments. This action would be dignified and would, at the same time, restore to them the confidence which they previously enjoyed in the eyes of the medical profession. We should be pleased to publish, for the information of all interested in this important matter, the records of each of the applicants.

THE HOOKWORM SURVEY IN BROKEN HILL.

A committee appointed by the Home and Territories Department of the Federal Government to deal with the Australian Hookworm Campaign, considered on January 30, 1920, the proposal that investigations should be extended to Broken Hill. It will be remembered that the International Health Board of the Rockefeller Foundation is collaborating with the Commonwealth Government in carrying out this survey. Late in November, 1918, the State Government of Queensland determined to participate in the scheme and Dr. J. H. Waite started a survey of the coastal district north and south of Cairns. The work was unfortunately interrupted owing to the illness of Dr. Waite. It has more recently been continued and extended under the direction of Dr. W. A. Sawyer, also a member of the Rockefeller Foundation. At present there are in Queensland three American experts and three Australian field medical officers (all returned men), while a fourth Australian officer will be appointed within a short time.

The Board of Trade of New South Wales has recently appointed a Commission for the purpose of establishing on a scientific basis the extent and nature of industrial diseases among the miners at Broken Hill. Professor H. G. Chapman has been appointed Commissioner and with him are associated Dr. S. A. Smith, Dr. W. A. Edwards, Dr. D. T. Rushton Smith and Dr. H. S. H. Wardlaw. Dr. Wardlaw is a graduate in science and has distinguished himself in bio-chemical researches.

The Committee on the hookworm campaign gave their approval to the proposal to extend the survey to Broken Hill and the Northern Territory.

A MEDICAL CRICKET MATCH.

By a Special Sporting Correspondent.

The Royal Prince Alfred Hospital versus The Sydney Hospital.

Not the least grateful sign of the world's peace was the resumption of the annual inter-hospital cricket match, which was played this year on January 28, 1920, at Rushcutter's Bay Oval, Sydney. For the first time the teams consisted entirely of members of the honorary staffs.

Steer Bowker won the toss from Purser and after carefully estimating the hygroscopic index of the pitch sent the Royal Prince Alfred Hospital men to the wickets. The teams took the field, the band playing appropriate music ("By Heavy Beasts the Earth is trod"—"The Creation"). Rain had made the wicket sticky and the batsmen found ample trouble in the bouncing deliveries of Stacy, who took five wickets. Bright spots were Molesworth's 25 (retired) and the hot catch by Maitland at mid-on, which ended Poate's career.

Sydney went to the wickets with 62 to get. Maitland made a steady 20 and Edwards retired with a brisk 21. Molesworth and Poate bore the brunt of the Royal Prince Alfred Hospital attack. Sydney made 82.

A remarkable feature of the match was the paucity of sundries, one bye being scored by Royal Prince Alfred Hospital; in fact, most remarkable, when one recalls Stacy's deliveries whipping up off the wicket and the Sydney wicket keeper crouching behind the heap of sawdust, asking the long-stop: "Where did that one go"? We are creditably informed that only thoughts of the world-shaking crisis

caused by the foot-faulting of Kingscote prevented Sydney's score being appreciably augmented by Molesworth.

The aforementioned band discoursed at intervals to a number of guests, who braved the fickle skies and were entertained at afternoon tea by the honorary staffs of the hospitals. The scores were:—

Royal Prince Alfred Hospital.

Dansey (run out)	8
Molesworth (retired)	25
Morton (b. Stacy)	1
Purser (b. Stacy)	4
Smith (b. Stacy)	3
Sandes (c. Maitland, b. Stacy)	0
Poate (c. Maitland, b. C. Bowker)	10
Woodburn (c. Bell, b. R. S. Bowker)	3
Sear (not out)	2
Tebbutt (b. Stacy)	4
Godsall (c. Bullock, b. Stacy)	0
Sundries	1
Total	61

Sydney Hospital.

Stacy (c. Poate, b. Molesworth)	0
Bowker, C. V. (b. Poate)	3
Maitland (c. Tebbutt, b. Sear)	20
Terrey (b. Molesworth)	9
Bowker, R. S. (l.b.w., b. Poate)	7
Edwards (retired)	21
Shepherd (run out)	1
Bullock (c. and b. Sear)	2
Aspinall (c. and b. Molesworth)	6
Bell (b. Poate)	7
Furber (not out)	6
Sundries	0
Total	82

[It has occurred to us that a match arranged between the members of the honorary staff of the hospitals in Sydney and those in Melbourne would be an admirable annual institution. The exhibition of friendly rivalry on the field could not but have the effect of drawing the medical profession in the two States more closely together. It is probable that the spectators would be at least as numerous as the audience to a scientific paper read by a member of the neighbouring Branch in either of the two capital cities.—Ed.]

Profound regret was expressed in Sydney on February 2, 1920, when the news arrived that Dr. George Thomas Hankins had died in London on January 20, 1920. Dr. Hankins was for many years Honorary Secretary of the New South Wales Branch of the British Medical Association and in this capacity performed invaluable services. We hope to publish a full account of his career in an early issue.

"THE AUSTRALIAN MEDICAL ASSOCIATION."

Not long ago a handful of medical practitioners banded together for purposes with which we are unacquainted, and announced that they would be known as the "Medical Society of Victoria." Unfortunately for this organization, that denomination had already been in existence for many years and the members of the real Medical Society of Victoria naturally resented that any other body should usurp its name. According to the *Age* of January 29, 1920, the first annual meeting of "The Australian Medical Association" took place at the headquarters of this body in Collins Street on January 24, 1920. It seems as if this body and the body that endeavoured to pass as the "Medical Society of Victoria" are related. Several attempts have been made in the past in different States to institute an Australian Medical Association, always in opposition to the Australian Branches of the British Medical Association. The success which has attended these endeavours, may be measured by the number of members of the British Medical Association at present in Australia. From the paragraph referred to, it would appear that this new body is out to assist the Premier and the Government of Victoria in their endeavour to obtain suitable medical men as whole-time or part-time medical officers for the schools or any other position that may be created under the provisions of the new Health Act. In other words, they hope to provide the friendly societies with medical officers for their medical institutes. The policy of the new association, in dealing with the friendly societies, we are informed, embraces a determination to conduct the agreements on a business-like basis of "give and take." The executive of this organization comprises the following: Drs. Gemmell Thomson, P. J. Godfrey, F. S. Pope, T. F. Hanly, L. R. Steele, H. D. Stead and C. D. Greenwood. It will be interesting to watch the development and achievements of this organization.

In the *South Australian Government Gazette*, No. 4, of January 22, 1920, the announcement is published that Dr. Frederick Wood Jones has been appointed Professor of Anatomy at the University of Adelaide. Professor Wood Jones possesses the high appreciation of his colleagues in England as a well-versed anatomist. The appointment is of great importance to the Medical School. We feel sure that the excellent work which Professor Watson has carried out for a number of years will be continued in an able manner by his successor.

We have received the news of the death of Dr. Charles Gabourel Thorp, of Onslow, Western Australia.

Correspondence.

BRAIN WEIGHT IN CONGENITAL MENTAL DEFICIENCY.

Sir,—It is a matter for regret that the author of the above contribution should have again ventured into the arena of critical and statistical science, thereby again laying himself open to attack all along the line.

He now tells us that the "object of the contribution was intended to show how varied the brain weights are in these cases" of congenital mental deficiency. Neurological science has long been familiar with the fact. Further, modern method has progressed beyond the peculiarities of people who "may not prefer to have the weights averaged"—though incidentally it may be stated that the "median" and the "average" are not quite the same thing—"but may like to see the actual figures for each case." It is such obsolete imaginings which have discredited so many papers professing to deal with statistical analysis. For the benefit of such peculiar people percentile tables suffice and have the added merit of complying with the demands of statistical method.

If such were the only object of the contribution it is difficult to understand why the author should have gone out of his way to make an anonymous attack on work which it is obvious he does not understand, an attack which, notwithstanding my refutation, he has again repeated. Apparently only very slightly familiar with one of my many writings of this subject, he quotes three entirely unrelated sentences in support of his misconception of the facts. Neither these, nor any other fragments from my work, warrant the sweeping and ridiculous assertion that they "undoubtedly strengthen the idea that congenital mental deficiency is always associated with low brain weight." The use of the word "always" is amusing, as is also Dr. Lind's consequential assumption that the profession is not familiar with the occurrence of macrocephalic idiocy.

Dr. Lind's use of figures is as remarkable as ever. His 142 cases are useless, because they range from birth upwards with never more than 7 cases in any one group, the adults excepted, and even these, correctly analysed, give the very opposite results to those with which Dr. Lind deludes himself. His *tu quoque* reminder that I based my results on 14 State school children and 39 mentally deficient children is also an error. In his anxiety to attack his critic, Dr. Lind has somewhat, unfortunately, overlooked certain facts. One, that the probable error of the group—15.09—was given, which is so high as to make it impossible to draw conclusions and, two, that no results were so drawn. If Dr. Lind would only read the paper he would save me the trouble of having to point out the obvious.

There is no question of the national importance, at the present grave juncture, of a correct study of the many problems of mental deficiency. Recent military records, particularly in England, have demonstrated the unpleasant fact that there is an unduly large and increasing proportion of class C. population and that with such a class it is impossible to make good the ravages of war. This being so, the use of improper methods with the consequent erroneous deductions cannot be permitted and it has been duty to expose the fallacies of such methods, though I need hardly add without the slightest personal animus.

I recognize the magnificent opportunities at Dr. Lind's disposal, and on my return from England later in the year, my experience and collaboration are at his disposal, as is also the literature of the Anatomy Department, if he cares to avail himself of them. *Verbum sat sapienti.*

Yours, etc.,

RICHARD J. A. BERRY.

University of Melbourne,
January 28, 1920.

Births, Marriages and Deaths.

The charge for inserting advertisements of Births, Marriages and Deaths is 5s., which should be forwarded in money orders or stamps with the notice, not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTH.

FINCKH.—On January 22, 1920, at "Myarork," Kirkoswald Avenue, Mosman, to Dr. and Mrs. A. E. Finckh a son.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser." page xxiii.

Department of the Navy: Six Medical Officers.

Sydney Hospital: Temporary Honorary Assistant Relieving Physician.

Brisbane Hospital: Resident Medical Officer.

Caboolture, Queensland: Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges (other than the Grand United Order of Oddfellows and the Melbourne Tramways Mutual Benefit Society), Institutes, Medical Dispensaries and other Contract Practice. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital. Chillagoe Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United Friendly Societies' Dispensary. Canterbury United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Friendly Society Lodges at Lithgow. Friendly Society Lodges at Parramatta, Auburn and Lidcombe. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society..
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

Feb. 11.—Tas. Branch, B.M.A., Annual Meeting.
Feb. 12.—Vic. Branch, B.M.A., Council.
Feb. 12.—Q. Branch, B.M.A., Council.
Feb. 25.—Vic. Branch, B.M.A., Council.
Feb. 26.—Q. Branch, B.M.A., Council.
Mar. 2.—N.S.W. Branch, B.M.A., Ethics Committee.
Mar. 3.—Vic. Branch, B.M.A..
Mar. 9.—Tas. Branch, B.M.A..
Mar. 9.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Mar. 11.—N.S.W. Branch, B.M.A., last day for nomination of candidates for election to the Council.
Mar. 11.—Vic. Branch, B.M.A., Council.
Mar. 11.—Q. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: City 2645.)